

Estrella Animal Hospital, Inc.

www.eahvets.com

Owner and Pet Information for Training

Welcome to obedience class! Thank you for giving us the opportunity to help you train your dog. Please help us to meet your needs better by taking a moment to share some important information we will need as we support your pet's training needs. Please fill out the forms below.

Owner Information

Last Name:		First Name:	
Co-owner Last Name:		Co-owner First Name:	
Address:		City:	State: Zip:
E-Mail Address:		Home Phone:	Emergency Phone:
How were you referred to us? Personal referral (Name)			

Pet Information

Name:	Breed:	M <input type="checkbox"/>	F <input type="checkbox"/>	Age:	Birth Date:
Color/Markings:		Sterilized: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Are this dog's vaccinations current? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown (Vaccinations must be current for obedience class)					
Date of rabies vaccine:			Date of DA2PP vaccine:		
Describe any difficulties your dog may have during the class (biting, lunging, fighting etc):					
Please describe any training or socialization problems your dog has experienced in the past:					

You must bring a corrective collar and leash to obedience class. These tools allow you to control your dog. You will be shown how to use these tools in order to control your dog. By signing below, you represent that your dog is friendly and not a hazard to people or other dogs. If the instructor asks you to leave the class for aggressive behavior, you must leave the class. No refunds are given if you are asked to leave class. You enter class at your and your dog's own risk.

ALL TRAINING FEES ARE DUE AT THE BEGINNING OF THE FIRST CLASS. We accept cash or personal check.

To prevent the spread of infections diseases, all dogs enrolled in training class must be current on all vaccines and free from internal and external parasites. **Proof of veterinarian given vaccines are required if not given at Estrella Animal Hospital.** The signature below authorizes this level of preventive care and you agree and understand the terms above.

Name:	Signature:	Date:
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