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**Animal Assisted Activities (AAA) Veterinary Form**

**All Information Must be Completed by a North Carolina Licensed Veterinarian (Print or Type)**

**Volunteer Services must receive a copy of this form annually**

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| **Name (Last, First)** | **Dog Name** |  |
| **Age (dog)**  | **Gender** **[ ]** Male **[ ]** Female**[ ]** Neutered **[ ]** Spayed | **Breed** |
| **Veterinarian** | **Veterinarian Phone Number** | **Practice Name** |
| **Hospital Contact Person****Jodie Skoff** | **Department Name****Volunteer Services** | **Email****jodie.skoff@unchealth.unc.edu****Fax****984-215-2036** | **Phone****984-215-2037** |

**Annual Exam Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Required Vaccinations**

* **Rabies When\_\_\_\_\_\_\_\_\_\_ expiration\_\_\_\_\_\_\_\_\_**
* **Da2PPV Booster When\_\_\_\_\_\_\_\_\_\_ expiration\_\_\_\_\_\_\_\_\_**

 **OR**

* **Distemper When\_\_\_\_\_\_\_\_\_\_ expiration\_\_\_\_\_\_\_\_\_**
* **Parainfluenza When\_\_\_\_\_\_\_\_\_\_ expiration\_\_\_\_\_\_\_\_\_**
* **Parvovirus When\_\_\_\_\_\_\_\_\_\_ expiration\_\_\_\_\_\_\_\_\_**

**Receiving routine medication for the prevention of heartworm?**

**Yes [ ]  No [ ]**

**Receiving routine flea and tick prevention?**

**Yes [ ]  No [ ]**

**(If none, the handler will be required to give Capstar 24 hours prior to the visit.)**

**Other Vaccinations**

**Yes [ ]  No [ ]**

* **Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When\_\_\_\_\_\_\_\_\_\_\_\_**
* **Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When\_\_\_\_\_\_\_\_\_\_\_\_**

**Other Medications**

 **Yes** [ ]  **No** [ ]

* **Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reason\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reason\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Veterinarian completing this form**

|  |  |  |
| --- | --- | --- |
| **Name (Please Print)** | **Signature** | **Date** |

2/16; 4/17; 3/20