

Lopez Island Pharmacy for animal use only

- PLEASE PRINT -

Owner's Name: _____

Animal's Name: _____ Circle : Dog Cat Other _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone:(____)_____ Cell:(____)_____ Pet's Date of Birth: _____

Owner's E-mail Address: _____

Please circle correct answer (where applicable)

Sex: M F Weight: _____lbs. Pregnant: Yes No Nursing: Yes No

Does your pet have any drug allergies? Yes No

If yes, please list: _____

Is your pet taking any other medications? Supplements? Yes No

If yes, please list: _____

Does your pet have any chronic health conditions or drug idiosyncrasies? If yes, please list.

Circle Preference: child resistant lids easy open lids Sign: _____