Vet Medical Clearance Form – Assistance Dogs

What is your client's:

First name: _____ Last name: _____

Dog's name? _____. Breed(s): _____

Sex: M / F Desexed: Y / N Age desexed: _____

Weight in kg: _____ Microchip number: _____

How would you rate the dog's general health?

◯ Excellent (no pain or chronic conditions)

◯ Very good (some minor complaints managed by treatment)

◯ Good (some ongoing chronic issues that may have flare ups requiring time off)

◯ Poor (chronic health concerns impacting daily living that would make working challenging)

Do you consider this dog's health to be appropriate for assistance dog work? Y / N

Are there adjustments to work that are required due to a health concern? Y / N

If yes, please describe: _____

Date of last C5 Vaccinations? ____ / ____ / _____ Date next due: ____ / ____ / _____

How long have you been treating this dog? _____

Does the dog have a regular flea and worming treatment program? Y / N

Signature: _____ Print Name: _____

Date: _____. Practice Name: _____

Suburb: _____ State: _____

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