

Name of Clinic Here  
Address  
Phone

Logo Here  
(if wanted)

## **PROOF OF VACCINATION FORM**

File No. \_\_\_\_\_

Pet Owner's Name: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Phone No.: \_\_\_\_\_

Pet Owner's Address: \_\_\_\_\_

Pet's Name: \_\_\_\_\_

Species:  Dog  Cat  Other \_\_\_\_\_ Breed: \_\_\_\_\_ Color: \_\_\_\_\_

Sex:  Male  Female Spayed/Neutered:  Yes  No DOB:

This animal has been vaccinated for:

## Dogs:

- |  |             |                     |
|--|-------------|---------------------|
| <input type="checkbox"/> DHPP          | Date: _____ | Date Expires: _____ |
| <input type="checkbox"/> Bordatella    | Date: _____ | Date Expires: _____ |
| <input type="checkbox"/> Rabies        | Date: _____ | Date Expires: _____ |
| <input type="checkbox"/> Leptosporosis | Date: _____ | Date Expires: _____ |
| <input type="checkbox"/> Lyme          | Date: _____ | Date Expires: _____ |

## Cats:

- FVRCP Date: \_\_\_\_\_ Date Expires: \_\_\_\_\_  
 Rabies Date: \_\_\_\_\_ Date Expires: \_\_\_\_\_  
 Feline Leukemia. Date: \_\_\_\_\_ Date Expires: \_\_\_\_\_

I certify that (pet's name) \_\_\_\_\_ is current on the vaccinations checked above.

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Veterinarian Signature

Date

## Notes: