Name of Clinic Here
Address
Phone

Logo Here
(if wanted)

# PROOF OF VACCINATION FORM

File No. _____

Pet Owner's Name: _____ 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:

| | | |
|---|---|---|
| ☐ DHPP | Date: _____ | Date Expires: _____ |
| ☐ Bordatella | Date: _____ | Date Expires: _____ |
| ☐ Rabies | Date: _____ | Date Expires: _____ |
| ☐ Leptosporosis | Date: _____ | Date Expires: _____ |
| ☐ 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.

_____

Veterinarian Signature Date

**Notes:**