

## Pet Care Emergency Authorization Form

To Whom it May Concern:

I, \_\_\_\_\_ (owner's name), owner of the below-described animal, authorize \_\_\_\_\_ (authorized agent's name) to make emergency veterinary medical decisions, including euthanasia (unless noted below), for the animal described below in the event that I cannot be reached. Where applicable, I have also listed guidelines and limitations of care. I accept financial responsibility for the emergency care of the animal(s).

Owner's name: \_\_\_\_\_

Owner's contact information in case of emergency (provide all forms of contact):  
 \_\_\_\_\_  
 \_\_\_\_\_

Other contacts (travel companions, etc. – name and contact information): \_\_\_\_\_  
 \_\_\_\_\_

Dates of travel or expiration date of this form: \_\_\_\_\_

Animal's name: \_\_\_\_\_

Type of animal: \_\_\_\_\_

Age, weight and sex of animal: \_\_\_\_\_

Description of animal (color, markings): \_\_\_\_\_

Relevant medical history: \_\_\_\_\_

Microchip number (if applicable): \_\_\_\_\_

Vaccinations (vaccination, date): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Medications (name, dose, frequency, route of administration):

Name	Dose	Frequency	How medication is given (orally, etc.)	Other notes

**Disclaimer:** This model form/document is a sample only, is not specific to the facts of any business or organization, and therefore should not be used or relied upon without the advice of retained legal counsel. This model form/document is not intended to provide legal advice or opinion and should not be construed as such.

Other medication notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Authorized agent: \_\_\_\_\_

Relationship to pet owner: \_\_\_\_\_

Contact information for authorized agent: \_\_\_\_\_  
\_\_\_\_\_

Other instructions, if applicable:

- I authorize emergency veterinary care costs up to \$ \_\_\_\_\_
- I do **not** authorize euthanasia without my direct consent.
- In the event of my animal's death, I wish for the following to be done with his/her remains: \_\_\_\_\_  
\_\_\_\_\_
- I do **not** authorize the following procedures/ treatments (provide a description of what is to be done in place of this procedure/treatment):
  - \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_
- Other: \_\_\_\_\_

Owner's name (printed): \_\_\_\_\_

Owner's signature: \_\_\_\_\_

Date: \_\_\_\_\_

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