



### Consent for Sterilization

Client Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Animal Name: \_\_\_\_\_ Species: DOG CAT Sex MALE FEMALE

Breed: \_\_\_\_\_ Color: \_\_\_\_\_ Age: \_\_\_\_\_

### CONSENT FOR SURGICAL STERILIZATION

I, being of legal age and responsible for the animal described above, have the authority to grant Animal Friends of Washington County – Connie Clinic and its staff members, volunteers or agents my consent to receive, transport, prescribe for, treat and/or perform sterilization procedures upon the animal described above.

I understand that modern techniques and trained staff will be utilized for the care of all animals, and reasonable precautions will be used to prevent injury, escape, or destruction of the animal. It is thoroughly understood that Animal Friends of Washington County – Connie Clinic and its staff members, volunteers, and agents will not be held liable or responsible in any manner and I assume all risks.

If in the course of treatment a condition is discovered that requires medical attention or an additional procedure, such as hernia repair or the administration of IV fluids, the attending veterinarian may, in his/her absolute discretion, perform such procedure. I consent to these procedures and any additional costs.

I further understand that as long as, in the opinion of the attending veterinarian, the animal is an acceptable surgical candidate, sterilization procedures will be performed regardless of the animal's sex or medical condition (such as the presence of heartworm disease or pregnancy). I understand the attending veterinarian can refuse to perform any procedure on any animal for any reason. Such refusal is at the absolute discretion of the attending veterinarian.

I understand that animals may be identified with a permanent microchip and that feral cats will have their left ear notched. I consent to these procedures and additional costs, if any.

I understand that all animals must be picked up from the clinic at the time designated by the staff on the same day as surgery. If I do not claim the animal, I understand that after 24 hours the animal will be considered abandoned and the animal will be disposed of in accordance with policy established by Animal Friends of Washington County – Connie Clinic. I understand that once an animal has been abandoned, I relinquish all ownership rights and I will be responsible for any and all medical costs including boarding expenses.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_