741 Kimball Rd.
Fort Collins, CO 80521
Call or Text (970) 481-9834
www.AirBudandB-FoCo.com

MEDICATION/SUPPLEMENT ADMINISTRATION FORM

Client First Name: _____ Last Name: _____

Pet Name_____

I am aware and understand that AirBud & B employees are not veterinarians and do not have backgrounds in animal medicine. AirBud & B employees are not expected to diagnose or detect illnesses in the pet that is under the care of AirBud & B. I agree to assume all risk associated with administration of medication/supplements by AirBud & B employees during my pet's stay. Administration of injections may incur a fee, per injection.

Client Signature _____ Date: _____

Medication/Supplement Name:_____

_____

For what condition/ailment is your pet being treated?_____

_____

Is there a specific way that you prefer to give their medication/supplement? If so, please explain in detail:_____

_____

Verify type of medication/ supplement and provide the exact count of medication being left at AirBud & B	❑ Ointment Count:	❑ Oral Count:	❑ Other (Specify) Count:

Medication to be administered/Dose	❑ Scheduled Daily	❑ AM	❑ Midday	❑ PM
If "As Needed" Please specify:	❑ As Needed		Max. Dosage:	Frequency:

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Medication to be administered/Dose	❑ Scheduled Daily	❑ AM	❑ Midday	❑ PM
If "As Needed" Please specify:	❑ As Needed		Max. Dosage:	Frequency:

❑ Please check here if additional Medication/Supplement Forms are needed.

*****You MUST provide original medication packaging and instructions as provided by your veterinarian*****

I hereby represent that all information provided on this entire Medication/Supplement Administration Form is true and accurate.

Client Signature: _____

Date: _____

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Medication/Supplement Administration Calendar

FOR AIRBUD & B STAFF USE ONLY

- Include the exact time the medication was administered and the initials of the person(s) administering it under AM/Midday/PM.
- Mark "NA" in each time slot in which medication was not requested or required.
- Dogs receiving medications "As Needed" must be evaluated at a minimum of three times daily (AM/Midday/PM) - confirm that the maximum daily dosage has not been exceeded prior to medicating.

Pet's Name:

Start Date:		End Date:	
Start Time:	AM / PM	End Time:	AM / PM

EMPLOYEE MUST INITIAL TIME THE MEDICATION/SUPPLEMENT IS ADMINISTERED

DATE	MED/SUPP	AM	MIDDAY	PM	NOTES

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Pet's Name:

Start Date:	End Date:
Start Time: AM / PM	End Time: AM / PM

EMPLOYEE MUST INITIAL TIME THE MEDICATION/SUPPLEMENT IS ADMINISTERED

DATE	MED/SUPP	AM	MIDDAY	PM	NOTES