

HSSM Spay/Neuter Clinic
(228) 863-3354 or (228) 863-8610

Animal ID No _____

Date of Surgery

Admission Form

Cert Adopt RTO TNR

Your first name _____ Your last name _____ Your pet's name _____
Approx. Weight _____ Pet's age or DOB _____

Your pet's species Cat Dog
Your pet's sex Male Female
Has your pet had a litter? Y N
If yes, how many 1 2 or more

Pet's color(s) _____ Pet's breed _____

Address _____ City _____ State _____ ZIP _____

Home phone with area code _____ Work phone with area code _____ Cell phone with area code _____

HSSM Spay/Neuter Clinic uses qualified staffing and approved materials for all procedures performed. I understand that the risk of injury or death, although extremely low, is always present just as it is for humans who undergo anesthesia and surgery. Carefully read and understand the following before signing your name. Please Initial Here _____

I, acting as owner or agent of the pet named above, hereby request and authorize HSSM Spay/Neuter Clinic, through whomever veterinarians they may designate, to perform an operation for sexual sterilization of the animal named on the above portion of this form.

I understand that the operation presents some hazards and that injury to or death of such an animal may conceivably result, for there is some risk in the procedure and the use of anesthetics and drugs in providing this service.

I either certify that my animal has been vaccinated within one year prior to this date or waive my right to protect my animal by having it vaccinated, or request recommended vaccinations at the time of surgery.

I understand the inherent risks of failing to maintain current vaccinations and waive all claims arising out of or connected with the performance of this operation due to such failure.

I understand that it takes up to two weeks for vaccinations to protect my animal.

I understand that if my animal is 6 years or older, I am required to provide the results of pre-anesthetic blood work from my pet's regular vet. Our veterinarian will then determine if the pet is an acceptable surgical candidate based on these results.

I certify that my animal is in good health and has had no food since 12:00 AM, midnight, the evening prior to surgery.

I certify that my animal is at least 3 months old and weighs at least 3 lbs.

I understand that HSSM Spay/Neuter Clinic may not perform a complete physical examination before surgery is performed.

I understand that some factors significantly increase surgical risk, including but not limited to, cryptorchid (retained testicles), pregnancy, in heat, and diseases such as FIV, Feline Leukemia, and heartworms.

I understand that if my animal is pregnant, the pregnancy will be terminated at surgery.

I understand that HSSM Spay/Neuter Clinic's veterinarian has the right to refuse service to any animal to whom surgery is deemed a health risk or for any other reason.

I understand that if I don't retrieve my pet at the agreed upon time that HSSM Spay/Neuter Clinic will exercise its right to relocate the animal to the HSSM animal surrender department. The animal will remain there as a stray as required by Mississippi law. Owners of pets left after the agreed date and/or time shall be charged a boarding fee of no less than \$10.

I hereby release HSSM Spay/Neuter Clinic, all veterinarians, assistants, volunteers, directors, and employees from any and all claims arising out of or connected with the performance of this procedure or any adverse reactions from vaccinations. I agree that I have not and will not claim any right of compensation from them, or any of them, or file action by reason of such sterilization or attempted sterilization of such animal or any consequences related thereto. We cannot be held responsible for any complications specifically those resulting from failure to follow post-op instructions, or for contagious diseases.

YOUR ANIMAL WILL RECEIVE A SMALL TATTOO ON HIS/HER UNDERSIDE TO SHOW THAT HE/SHE HAS BEEN STERILIZED.

Requested Feline Vaccines and Services

3 Year Rabies Vaccine Ear Tip (TNR ONLY)
 FVRCP Nail Trim
 Microchip Post Op Pain Med

Requested Canine Vaccines and Services

3 Year Rabies Vaccine Other _____
 DA₂PP Nail Trim
 Microchip Post Op Pain Med

I HAVE PROOF OF CURRENT RABIES VACCINATION - Staff Initials _____

I have read and understand the information provided on this form and agree to the outlined terms

SIGNATURE

PRINT NAME

DATE

DAY OF SURGERY PHONE NUMBER