



Certified Therapy Dogs of America Dog Health Form

Handler name: _____

Handler email: _____ Handler phone number: _____

Dog name: _____ Dog Breed: _____

Dog Date of Birth: _____

Veterinary Name: _____ Phone #: _____

Veterinary Address: _____

Veterinary City, State, And Zip: _____

Veterinarian Information

Date of annual wellness check: _____

Date of most current negative fecal check: _____

Date of most current rabies vaccination: _____

If you agree to the following statement, sign below:

The dog has been examined by this clinic, and it is believed that the dog is healthy.

Veterinarian Signature: _____ Date: _____

Terms:

If any vaccinations are expired, then the form is expired.