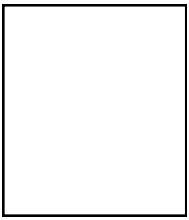
Central Texas Veterinary
SPECIALTY & EMERGENCY
HOSPITAL

Pet Information Card

Meet: _____



Breed: _____

Age/DOB: _____

Sex: (Please Circle) Male / Female
Spayed / Neutered / Intact

Color: _____

Date of last rabies vaccine: _____

Current Medications: _____

_____

Important Medical History: _____

_____

In Case of Emergency

My Name: _____

Phone Number: _____

Address: _____

Primary Care Clinic: _____

Phone Number: _____

24 Hour Emergency Care

Central Texas Veterinary
SPECIALTY & EMERGENCY
HOSPITAL

Medical Decision Making

In the event of an emergency, if I cannot be reached, the following individuals are permitted to make medical decisions on my behalf:

Name: _____

Phone Number: _____

Name: _____

Phone Number: _____

Signature: _____

Date: _____

Additional Notes

_____

_____

_____

_____

_____

_____

_____