Jacob Kail
Canine Massage Therapist
BSc Human Sports Therapy
Canine Sports Massage (TCAP)

KAIL'S TAILS
CANINE MASSAGE & PET CARE SERVICES

FOR COMPLETION BY OWNER

Owner's name:	Mobile No:	
Telephone No:	Dog's name:	
Address:	Breed:	
	Gender:	DOB:
Reason for treatment request:		

I am the legal owner of the above named dog and all information supplied is correct to the best of my knowledge. I give consent for my dog to be treated by Jacob Kail of Kail's Tails.

Print name*:* _____ *Signature:* _____

Date*:*_____

FOR COMPLETION BY VETERINARIAN

Veterinarian:	Telephone number:
Practice address/practice stamp:	
Reason for approach/areas of concern – please attach further notes on medical history if necessary:	

"I hereby give veterinary consent for Jacob Kail to treat this animal."

Name: _____ *Position:* _____

*Signature:*_____ *Date:* _____

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