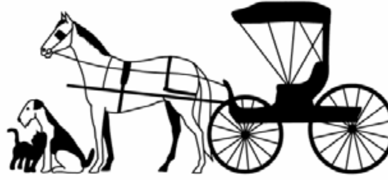
Please fill out this form,
print, sign, and send back
to JVC via fax: (317)758-6055
email: info@janssenvetclinic.com
or postal delivery.



JANSSEN VETERINARY CLINIC
2420 WEST 236TH STREET
SHERIDAN, IN 46069-9305
317-758-4865

Equine Hospitalization Form

Client Name: ______________________________________
Address: ____
City/State: ______________________________________
Telephone: _______________________________________

Equine Name:______________________________________
Breed:____
Sex: Mare Gelding Stallion
Color:____
Birth Date:_______________________________________

I certify that I own/have assumed financial responsibility for the equine described above, and I do hereby consent and authorize Janssen Veterinary Clinic and its staff to hospitalize this animal, and to administer vaccinations, medications, tests, surgical procedures, anesthetics or treatments (including fleas) that the doctors deem necessary for the health, safety or well-being of the above animal while it is under their care and supervision.

If this animal should injure itself in an escape attempt, refuse food, become ill or die while in the hospital, I will hold Janssen Veterinary Clinic free of any responsibility and/or liability in the absence of gross negligence.

I further realize that I am responsible for payment for the above procedures and treatments in full at the time the animal is discharged. If I neglect to pick up the animal that is ready for release, within five (5) days of written notice delivered to the above address, Janssen Veterinary Clinic may assume that the animal is abandoned. Janssen Veterinary Clinic is then authorized to dispose of it as they see fit. Abandonment does not release me of my obligation for the bill.

I further agree that in the case of non payment, a finance charge of 1 3/4% per month (21% per annum) will be charged and that any collection fees or attorney fees will be paid by me. If payment arrangements have not been made within 60 days of service, this account will be given to a collections agency. An additional non-refundable fee of $30.00 will be added to your account. This fee covers the cost of the collections agency.

Signed______________________________________Date_______/_______/______

JANSSEN VETERINARY CLINIC, LLC
EQUINE HOSPITALIZATION INSTRUCTIONS

Client Name:____
Patient Name:____

CHECK-IN WEIGHT: _____________________ DATE: _________________

PREVENTATIVE VETERINARY CARE:

Last Deworming Date: _______________ Product: _____________

Vaccinations Due - EWT RF WNV Strangles RABIES PHF

Fecal Exam: YES NO Sheath Cleaning: YES NO Farrier Work: YES NO

Special Requests - ____

FEEDING INSTRUCTIONS:

Grain ___________________AM/PM Hay ________________AM/PM

Supplements/Medications:

______________________Dose_________ AM PM
______________________Dose_________ AM PM
______________________Dose_________ AM PM
______________________Dose_________ AM PM

EXERCISE INSTRUCTIONS: Turnout: YES NO

Special Requests ____

Equipment Left with Equine: ____

Insured: YES NO
Insurance Co. Name: ________________________ Insurance Co. Phone: ____________
Owner daytime phone number: ____________________

I have read and filled out the above recommendations that I wish my equine to have completed while hospitalized at Janssen Veterinary Clinic, LLC.

Signed:____Date:______________