



Urban Pooch Canine Life Center
4501 N. Ravenswood Avenue ♥ Chicago, IL 60640-5201
773-942-6445 ♥ Fax: 773-942-6864 ♥ www.urbanpooch.com

I understand that before my dog(s) can play or board at Urban Pooch the following requirements must be met:

- My dog must pass a **socialization test** to ensure safety and no aggressive behavior toward other dogs or people.
- My dog's complete **veterinary inoculation records** must be furnished to Urban Pooch including Rabies, Distemper/Parvo, Bordetella **and** a fecal exam for parasites.
- My dog must be **spayed or neutered**. Puppies must be neutered by six months.
- My dog must have a City of Chicago dog license (Municipal Code 7-12-140). www.chicityclerk.com
- My dog must wear a **collar with ID** securely attached at all times while at Urban Pooch.

Signature _____

Date _____

OWNER INFORMATION

First Name: _____ Last Name: _____

Spouse/Partner First Name: _____ Last Name: _____

Address: _____ Unit/Apt: _____

City, State, ZIP: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Birth Month/Day _____ / _____

Spouse/Partner:

Work Phone: _____ Cell Phone: _____

Email: _____ Birth Month/Day _____ / _____

Credit Card: Master Card VISA

This information will be held in the strictest confidence and used only with your approval to pay for products and/or services at Urban Pooch

Card Number: _____ Expires: (mm/yyyy) _____

Billing Address (if different than above): _____ CV2 Number _____

Authorization Signature: _____

Emergency Contact

Name: _____ Relationship: _____

Phone Number(s): _____

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DOG INFORMATION

First and Last Name: _____ Gender: Female Male

Breed: _____ Color/Markings: _____

Weight: _____ Birthday/Adoption Date: ____/____/____

Spayed/Neutered? Yes No If no, surgery is scheduled for: _____

My Dog's Sibling (if applicable):

Name: _____ Gender: Female Male

Breed: _____ Color/Markings: _____

Weight: _____ Birthday/Adoption Date: ____/____/____

Spayed/Neutered? Yes No If no, surgery is scheduled for: _____

Veterinary Information:

Primary Clinic: _____ Doctor: _____

Address: _____ City, State, ZIP: _____

Phone Number: _____

Other Important Information:

My dog has a pre-existing physical/medical condition (i.e. injuries, scars, sensitive stomach): Yes No

(If yes, please explain) _____

My dog is on medication: Yes No

Name: _____ Condition/Reason: _____

Dosage (amount and frequency): _____

Special Notes/Instructions: _____

My dog eats _____ meals per day. Amount: _____ Brand: _____

Dry: _____ Can: _____ Restrictions: _____

Food Allergies: Yes No If yes, what? _____

Other People Authorized To Pick Up My Dog (s):

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____