

Puppy Preschool Registration
 Shiloh Veterinary Hospital
 Ages 7-12 Weeks

Your Name: _____ Puppy Name: _____

Breed of Puppy: _____ Date of Birth: ___/___/___ Male or Female (circle one)

Address: _____ City: _____

State: _____ Zip: _____ Phone # (best # to reach you in case of cancellation): _____

Email address (for class confirmation) _____

Age of handler if less than 16 (minimum handler age is 12; ages 12-15 must be accompanied by a parent or guardian) _____ Name of parent/guardian: _____

I am registering for ***4-week Puppy Pre-School*** at the Manchester area office held on Thursdays at 6:00pm (pup must be between 7 & 12 weeks on first day of class). I understand the classes are held in the basement with stairway access only. Registration fee: \$85.00

**** Pre-School classes are given on an ongoing 4-week format. Puppies may begin any week and continue for 4 weeks***

Pre-School puppies are required to have had at least 1 DHLPP & 1 Bordetella vaccine no sooner than 10 days prior to the first day of class. Please attach a copy of your pup's vaccine records if your puppy is not a patient of our practice.

Vaccine Dates:

1 st DHLPP: ___/___/___	2 nd DHLPP: ___/___/___	3 rd DHLPP: ___/___/___
Bordetella: ___/___/___		
Rabies (only given at age 12 weeks or older): ___/___/___		

Puppies are required to have had a negative stool sample for intestinal parasites or to be undergoing treatment for parasites. Date of last stool sample: ___/___/___ Result: _____

My puppy is currently taking veterinarian-prescribed medication to treat the following parasite(s):

If your puppy has been diagnosed with any transmittable diseases, including skin conditions, please state the diagnosis and the treatment: _____

What would you like to accomplish by taking this class? _____

Please read and sign the following agreement as a condition of acceptance of this application:

I understand the attendance of puppy classes is not without risk of injury or illness to me, my dog, or any guests who accompany me to class. I hereby waive and release Wendy Hazenstab (trainer), her assistants, the Shiloh Veterinary Hospital, its owners and employees, from any claim for injury or illness caused or allegedly caused directly in relation to attendance of class. I understand that by signing this form I am releasing Wendy Hazenstab, her assistants, the Shiloh Veterinary Hospital, its owners and employees from any liability for injury or damages occurring on the premises where classes are held before, during or after class.

I understand the class fee is for 4 or 6 consecutive classes, and if I miss a class there are no make-up classes and no refund will be granted.

I understand that photos or video footage may be taken during class for educational or marketing purposes. If I object to images being taken of me, my family or my dog I will communicate that to the trainer who will honor my wishes.

I understand that only humane methods will be used in the above mentioned classes and that no physical or emotional harm will intentionally be done to my pet while on the premises.

Signature: _____ Date: ___/___/___

Please complete and return the following by mail or in person:

Wendy Hazenstab Shiloh Veterinary Hospital 110 Morgan Lane York, PA 17406	Or	Wendy Hazenstab Shiloh Veterinary Hospital 2401 Emig Mill Road Dover, PA 17315
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Please make payment to Shiloh Veterinary Hospital

Payment may be made at either office with cash, check or a credit card. You may also mail a check or make a credit card payment over the phone by calling 717-767-0180.

Thank you! I look forward to working with you and your puppy.

Wendy