Animal Alliance ofCape May County, Inc.
(AACMC) 609-465-6388
P.O. Box 172
Cape May, NJ 08204

If you wish to make a donation to help our clinic operations, please make donations payable to AACMC.
We appreciate your help and thank you for your support
Stray/Feral Fund: _____
Services: _____
Total Enclosed: _____
Cash or Money Orders Only Please

Surgery Consent Form – General Public

To schedule an appointment, return this page only with your payment to AACMC at the address above. Please send money order or bank check only, no personal checks please. Once your consent form is processed, you will be contacted with your appointment date, drop off and pick up times, care instructions and driving directions.

INCOME ELIGIBILITY PROOF REQUIRED (please circle the one that applies/attach copy paperwork)
FS GPA RA AID MED Life U Life T PAAD SSI Senior (62+) Gross household income under /$40,000
(You may qualify to have your animal fixed for only $10. Please ask about the state program.)

Your Name _____

Address_____

Colony
Location_____

Home Phone (_____)_____ Cell (_____)_____

Work #(_____)_____ E-Mail:

☐ Check here if you have been to one of our clinics before.

☐ Check here if you are a new client…Please tell us how you heard about us.

_____

CONSENT-MUST BE READ AND SIGNED: I am the owner, or the authorized agent for the owner, of the animals described on this sheet, and I have the authority to execute this consent. I hereby give AACMC, Dr. Schwert, or any other veterinarian contracted by AACMC, volunteers and any other authorized agents, staff, or representatives consent and authority to perform spay/neuter surgery for the pet(s) listed on this form. The nature of these operations or procedures has been explained to me, and I understand what will be done. I have also been informed that there are certain risks and complications associated with any operation or procedure of this type. They have been explained to me as well. I further understand that during the course of the operations or procedures, unforeseen conditions may arise that may necessitate the performance of additional procedures. I authorize the use of appropriate anesthesia and pain relief medication as needed before or after the procedure. I have been informed that there are risks associated with the use of anesthesia and any medication, including possible injury and even death.
I agree to accept risks and release AACMC, volunteers, staff and veterinarian from any liability. I understand that clinic support personnel will be used as deemed necessary by the veterinarian. I understand that I am financially responsible for all post-operative veterinary care. I understand that $25/animal will be deducted from my refund if I do not give 48 hours notice of cancellation, and that I must arrive to pick up my pet at the scheduled time or I will be charged at a rate of $20 per 15 minute interval until I arrive.

Signed: _____ Date: _____ Total Due:_____
Payable to AACMC. Payment in full required

Regular Veterinarian:_____

**Any health problems?_____ If yes, describe _____ Shots/Vaccines's up to date: Y/N_____

#	Sex	Name of Pet	Age	S/L Hair	Color	Friendly Y/N	Do you want Rabies Vacc.? Y/N	Do you want Distemper Vacc? Y/N	Do you want? Ear Tip?