



# Thera-Fit Health Certificate

Patient: Name \_\_\_\_\_ DOB/Age \_\_\_\_\_ Breed \_\_\_\_\_  
Sex: Male  Female  Spayed  Neutered   
Vaccination status: Rabies due \_\_\_\_\_ DHLPP due \_\_\_\_\_

Current Weight: \_\_\_\_\_ Ideal Weight: \_\_\_\_\_

Client: Name \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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Special considerations or precautions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Veterinarian and hospital name: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

Your signature is required to certify that this patient is currently healthy enough to pursue physical activity.

Veterinarian Signature: \_\_\_\_\_ Date: \_\_\_\_\_