



## Massage Therapy Release Form

Veterinary clinic: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Client: \_\_\_\_\_ Pet: \_\_\_\_\_

To the best of my knowledge the above list dog is fit to receive canine massage therapy.

**Precautions/Contraindications:**

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**Other pertinent medical conditions/medications:**

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Please feel free to reach out with any questions at [Oklahomak9pt@gmail.com](mailto:Oklahomak9pt@gmail.com) or (918) 856-6018. Our Fax is (918) 600-1948 Thank you for your time.

\_\_\_\_\_  
DVM Signature

\_\_\_\_\_  
Date