FOREST PRESERVES of Cook County

VETERINARIAN FORM FOR OFF-LEASH DOG AREAS

PERMITS ARE VALID OCTOBER 1 THROUGH SEPTEMBER 30 OF THE FOLLOWING YEAR

Name of Applicant/Owner: _____ **Phone #:** _____

Online Receipt Number ***(if any)*****:** _____

*****The following must be completed by a licensed veterinarian.***

Although, not required, the District strongly recommends the Canine Influenza vaccination. Submit completed forms via email, fax or USPS mail.

Veterinarian Information:			
Name of Licensed Veterinarian (please print):			
Street Address:			
City	State:	Zip Code:	Phone:

At the time of examination for the dog(s) listed below, the dog(s) appears free of all communicable diseases (examination date must be within (1) year of applying for permit.

Veterinarian Signature: _____ Veterinarian License Number: _____

Veterinarian Address Stamp (if applicable):

Name of Dog 1	**Breed/Type of Mix**	**Rabies Tag #**

List dates of vaccinations below for Dog 1 below

Distemper	Hepatitis	Parvovirus	Leptospirosis	Bordetella	Parainfluenza	Rabies ☐1 yr. OR ☐3 yr.	Canine Influenza *(if applicable)*
___ / ___ Mo. Yr.	___ / ___ Mo. Yr.	___ / ___ Mo. Yr.	___ / ___ Mo. Yr.	___ / ___ Mo. Yr.	___ / ___ Mo. Yr.	___ / ___ Mo. Yr.	___ / ___ Mo. Yr.

Fecal Test Result Date (*must be within **120 days** of submission*): ☐ Negative ☐ Positive **Date of Result**: ___ / ___ / ____ Mo. Day Yr.

Name of Dog 2	**Breed/Type of Mix**	**Rabies Tag #**

List dates of vaccinations below for Dog 2 below

Distemper	Hepatitis	Parvovirus	Leptospirosis	Bordetella	Parainfluenza	Rabies ☐1 yr. OR ☐3 yr.	Canine Influenza *(if applicable)*
___ / ___ Mo. Yr.	___ / ___ Mo. Yr.	___ / ___ Mo. Yr.	___ / ___ Mo. Yr.	___ / ___ Mo. Yr.	___ / ___ Mo. Yr.	___ / ___ Mo. Yr.	___ / ___ Mo. Yr.

Fecal Test Result Date (*must be within **120 days** of submission*): ☐ Negative ☐ Positive **Date of Result**: ___ / ___ / ____ Mo. Day Yr.

Name of Dog 3	**Breed/Type of Mix**	**Rabies Tag #**

List dates of vaccinations below for Dog 3 below

Distemper	Hepatitis	Parvovirus	Leptospirosis	Bordetella	Parainfluenza	Rabies ☐1 yr. OR ☐3 yr.	Canine Influenza *(if applicable)*
___ / ___ Mo. Yr.	___ / ___ Mo. Yr.	___ / ___ Mo. Yr.	___ / ___ Mo. Yr.	___ / ___ Mo. Yr.	___ / ___ Mo. Yr.	___ / ___ Mo. Yr.	___ / ___ Mo. Yr.

Fecal Test Result Date (*must be within **120 days** of submission*): ☐ Negative ☐ Positive **Date of Result**: ___ / ___ / ____ Mo. Day Yr.