

4 WEEK CALENDAR FOR: _____

DATES: _____ TO _____

1 2 3 4 5 6 7 8 9 10 <input type="checkbox"/>	1 2 3 4 5 6 7 8 9 10 <input type="checkbox"/>	1 2 3 4 5 6 7 8 9 10 <input type="checkbox"/>	1 2 3 4 5 6 7 8 9 10 <input type="checkbox"/>	1 2 3 4 5 6 7 8 9 10 <input type="checkbox"/>	1 2 3 4 5 6 7 8 9 10 <input type="checkbox"/>	1 2 3 4 5 6 7 8 9 10 <input type="checkbox"/>
1 2 3 4 5 6 7 8 9 10 <input type="checkbox"/>	1 2 3 4 5 6 7 8 9 10 <input type="checkbox"/>	1 2 3 4 5 6 7 8 9 10 <input type="checkbox"/>	1 2 3 4 5 6 7 8 9 10 <input type="checkbox"/>	1 2 3 4 5 6 7 8 9 10 <input type="checkbox"/>	1 2 3 4 5 6 7 8 9 10 <input type="checkbox"/>	1 2 3 4 5 6 7 8 9 10 <input type="checkbox"/>
1 2 3 4 5 6 7 8 9 10 <input type="checkbox"/>	1 2 3 4 5 6 7 8 9 10 <input type="checkbox"/>	1 2 3 4 5 6 7 8 9 10 <input type="checkbox"/>	1 2 3 4 5 6 7 8 9 10 <input type="checkbox"/>	1 2 3 4 5 6 7 8 9 10 <input type="checkbox"/>	1 2 3 4 5 6 7 8 9 10 <input type="checkbox"/>	1 2 3 4 5 6 7 8 9 10 <input type="checkbox"/>
1 2 3 4 5 6 7 8 9 10 <input type="checkbox"/>	1 2 3 4 5 6 7 8 9 10 <input type="checkbox"/>	1 2 3 4 5 6 7 8 9 10 <input type="checkbox"/>	1 2 3 4 5 6 7 8 9 10 <input type="checkbox"/>	1 2 3 4 5 6 7 8 9 10 <input type="checkbox"/>	1 2 3 4 5 6 7 8 9 10 <input type="checkbox"/>	1 2 3 4 5 6 7 8 9 10 <input type="checkbox"/>

Please fill out and fax or send to us.
 Fax # 541-746-0599
 Mail to:
 Veterinary allergy & Dermatology
 5105 Main Street
 Springfield, OR 97478

KEY
AS= ALLERGY SERUM
AB= ANTIBIOTIC
AF=ANTIFUNGAL (KETO, ITRA, FLUCON.)
AH= ANTIHISTAMINES (HYDROX, BENADRYL, ETC)

S= STEROIDS
TO=TOPICAL OTHER
BA= BATH
F= FOOD
E= EAR MEDS/CLEANING