Pet Sitting Essentials

Client's name:
Pet's name:
Client's address:

Feeding:

AM Time:	PM Time:
Brand:	Amount:
Allergies:	Medications:

Daily Routine:

Normal outdoor time:	Normal walking time:
Water plants?	Alternate blinds/lights?
Bring in mail?	Turn on/off TV?

Equipment Location:

Leashes	Treats
Food	Can opener
Litter box	Toys
Litter supplies	Medicine
Broom/Vacuum	Dog Towels

Please circle yes or no, if yes please elaborate in “additional information” section.

Has this pet been aggressive?	Yes / No
Is this pet good with children?	Yes / No
Should pet be approached with caution?	Yes / No
Pets reaction toward being left alone:	Favorite toys / Play activity:

Additional information and instructions: