

Client Consent Form
Investigation of Vaccine Reactions in Dogs

Veterinarians at Purdue University's School of Veterinary Medicine, in conjunction with the American Kennel Club Canine Health Foundation, are leading a study in 2007-2008 to investigate the causes of allergic-type vaccine reactions in dogs. Some small breeds, such as Dachshunds, Pugs, Boston Terriers, Miniature Pinschers, and Chihuahuas, appear to be more susceptible to these reactions compared to other larger breeds.

The study will involve the collection of a small blood sample (approximately 3-5ml) for analysis. Once analyzed, the collective results from several hundred pets are expected to add important knowledge and understanding of the causes of allergic-type vaccine reactions in small dogs. This information will then provide a valuable impetus to vaccine manufacturers to improve canine vaccines by reducing or removing those chemicals or compounds stimulating reactions.

Your pet matches the criteria (breed, age, health and vaccination history) developed for this study and you agree by signing this form to give permission for your pet to be entered into the study. Your participation is purely voluntary, the test is provided at no cost to you, and only involves the submission of this one blood sample. Specific information that might identify you or your pet will be kept confidential.

One day, vaccine reactions will not be as prevalent as they are today, thanks to the contributions of individual pets like yours. Thank you for agreeing to enter your dog into this study. If you have any questions about this study, please contact Dr. Moore at 765-496-3393 or gemoore@purdue.edu.

Sincerely,

George Moore, DVM, PhD, and Harm HogenEsch, DVM, PhD
Project Investigators, Purdue University

Yes! I agree to the above and want to enter my pet into this vaccine-related study. I understand that there will be no cost to me, and that all samples and information derived from the study will belong to the study sponsor. I understand

Owner Name:

Pet Name:

Owner Signature: _____

Date: _____

Hospital Name:

Hospital Phone: