

| Contact/handling on treatment mat & off (on raised surface and floor): Say name of body part then contact | | |
|--|----------------------------------|--|
| Ears | Down <input type="checkbox"/> | Sitting <input type="checkbox"/> Standing <input type="checkbox"/> |
| Muzzle | Down <input type="checkbox"/> | Sitting <input type="checkbox"/> Standing <input type="checkbox"/> |
| Lips | Down <input type="checkbox"/> | Sitting <input type="checkbox"/> Standing <input type="checkbox"/> |
| Chin | Down <input type="checkbox"/> | Sitting <input type="checkbox"/> Standing <input type="checkbox"/> |
| Neck | Down <input type="checkbox"/> | Sitting <input type="checkbox"/> Standing <input type="checkbox"/> |
| Shoulders | Down <input type="checkbox"/> | Sitting <input type="checkbox"/> Standing <input type="checkbox"/> |
| Chest | Down <input type="checkbox"/> | Sitting <input type="checkbox"/> Standing <input type="checkbox"/> |
| Front legs (upper) | Down <input type="checkbox"/> | Sitting <input type="checkbox"/> Standing <input type="checkbox"/> |
| Front lower legs | Down <input type="checkbox"/> | Sitting <input type="checkbox"/> Standing <input type="checkbox"/> |
| Front paws | Down <input type="checkbox"/> | Sitting <input type="checkbox"/> Standing <input type="checkbox"/> |
| Withers | Down <input type="checkbox"/> | Sitting <input type="checkbox"/> Standing <input type="checkbox"/> |
| Back | Down <input type="checkbox"/> | Sitting <input type="checkbox"/> Standing <input type="checkbox"/> |
| Rump | Down <input type="checkbox"/> | Sitting <input type="checkbox"/> Standing <input type="checkbox"/> |
| Tail | Down <input type="checkbox"/> | Sitting <input type="checkbox"/> Standing <input type="checkbox"/> |
| Butt | Down <input type="checkbox"/> | Sitting <input type="checkbox"/> Standing <input type="checkbox"/> |
| Thighs | Down <input type="checkbox"/> | Sitting <input type="checkbox"/> Standing <input type="checkbox"/> |
| Hocks | Down <input type="checkbox"/> | Sitting <input type="checkbox"/> Standing <input type="checkbox"/> |
| Lower rear legs | Down <input type="checkbox"/> | Sitting <input type="checkbox"/> Standing <input type="checkbox"/> |
| Rear paws | Down <input type="checkbox"/> | Sitting <input type="checkbox"/> Standing <input type="checkbox"/> |
| VET CARE: (practice on a table on treatment mat) Default 'stand' on mat | | |
| Open mouth | Down <input type="checkbox"/> | Sitting <input type="checkbox"/> Standing <input type="checkbox"/> |
| Examine ears- incl. simulated scope | <input type="checkbox"/> | |
| Examine eyes- incl. simulated scope | <input type="checkbox"/> | |
| Restraint | Down <input type="checkbox"/> | Sitting <input type="checkbox"/> Standing <input type="checkbox"/> |
| Lifting | Down <input type="checkbox"/> | Sitting <input type="checkbox"/> Standing <input type="checkbox"/> |
| Fake injections (pinch/poke) | Sitting <input type="checkbox"/> | Standing <input type="checkbox"/> |
| Fake blood draw (front/rear legs and neck) | Sitting <input type="checkbox"/> | Standing <input type="checkbox"/> |
| Pill taking | <input type="checkbox"/> | |
| Syringe 'meds' | <input type="checkbox"/> | |
| Taking temperature | <input type="checkbox"/> | |
| Listen to heart | Down <input type="checkbox"/> | Sitting <input type="checkbox"/> Standing <input type="checkbox"/> |
| Laying in "hip X-ray position" | <input type="checkbox"/> | |
| Eye drops | <input type="checkbox"/> | |
| Ear drops/wash | <input type="checkbox"/> | |
| Get urine sample with ladle | <input type="checkbox"/> | |
| Belly band | <input type="checkbox"/> | |
| Bandages (foot, head, belly, leg) | <input type="checkbox"/> | |
| Cone | <input type="checkbox"/> | |
| Muzzle | <input type="checkbox"/> | |
| Routine care: | | |
| Brushing/shedding blade | <input type="checkbox"/> | |
| Teeth brushing/inspection | <input type="checkbox"/> | |
| Open mouth wide | <input type="checkbox"/> | |
| Nail trims | <input type="checkbox"/> | |
| Ear/eye cleaning & inspection | <input type="checkbox"/> | |
| Turn around | <input type="checkbox"/> | |
| Lie on other side/roll over | <input type="checkbox"/> | |
| Baths | <input type="checkbox"/> | |
| Foot wiping | <input type="checkbox"/> | |