Health records are meant to convey necessary information to all people involved in an animal’s care. Every facility is expected to have a system of health records sufficiently comprehensive to demonstrate the delivery of adequate health care. It is expected there will be an established health records system consistent with professional standards that meets and probably exceeds, the minimum requirements set forth in this policy. For all facilities, health records must be current, legible, and include, at a minimum, the following information:

- Identity of the animal
- Descriptions of any illness or injury and the resolution of any noted problem.
- Dates, details, and results (if appropriate) of all medically-related observations, examinations, tests, and other such procedures.
- Dates and other details of all treatments, including the name, dose, route, frequency, and duration of treatment with medications (a “check-off” system to record when treatment is given each day may be beneficial).

Examples of procedures that should be adequately documented in health records include, but are not limited to, vaccinations, fecal examinations, radiographs, surgeries, medical treatments, and necropsies. Routine husbandry and preventive medical procedures (e.g., vaccinations and dewormings) performed on a group of animals may be recorded on herd-health-type records. As long as all required information is readily available, records may be kept in any convenient format.

Health records must be readily available for review as requested (e.g., by an attending veterinarian, federal regulators, members of the IACUC, and AAALAC site visitors).

An animal’s health record must be held for at least 3 years after the animal’s disposition (e.g., adoption, sale or death). When an animal is transferred to another party or location, a copy of the animal’s health record must be transferred with the animal.

REVISED: December 18, 2012