

ANIMAL BITE INCIDENT REPORT

NOTE: THIS FORM IS TO BE COMPLETED BY HEALTH CARE PROFESSIONAL (OR OTHER AUTHORITY) AND FAXED TO THE HEALTH DISTRICT WITHIN 24 HOURS OF EXPOSURE

IMPORTANT: ALL ANIMALS INVOLVED IN A BITE INCIDENT NEED TO BE OBSERVED FOR 10 DAYS. NO ANIMALS SHOULD BE KILLED! IF THE ANIMAL IS NOT AVAILABLE FOR OBSERVATION CALL GRANT COUNTY HEALTH DISTRICT IMMEDIATELY. (509) 754-6060

VICTIM IDENTIFICATION: (person(s) bitten or definitely exposed to saliva)

Name: _____ Age: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Bite/Exposure: _____ Describe Injury (location of injury, number of puncture marks, etc.): _____

Describe Treatment: _____ Antibiotics: Yes () No ()

Physician: _____ Medical Facility: _____ Phone: _____

Describe incident (list briefly what patient had been doing just previously to bite or other exposure and how exposure took place): _____

ANIMAL IDENTIFICATION: Stray () Pet () Wild ()

Owner's Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Type of Animal: _____ Sex: _____ Age: _____ Name: _____
(Species, breed, color, full description of animal)

Current Rabies Vaccination: No () Yes () Date of last vaccination: _____

Has animal been spayed/neutered?: Yes () No ()

Veterinarian (or Veterinary Clinic): _____ City/State: _____

Is animal of local origin?: Yes () No () If no, place of origin: _____

Has animal been out of state in the past 6 months?: No () Yes () If yes, where?: _____

Animal was: Placed under quarantine () Killed () If either, by whom and where (give details; include phone number)? _____

Is/was animal ill? No () Yes () If yes, give details: _____

Animal's clinical symptoms during week previous to exposure compared to animal's normal behavior:

Vicious: Yes () No () Irritable: Yes () No ()

Paralysis of muscles: Yes () No () Unusually quiet: Yes () No ()

Difficulty swallowing, drooping of lower jaw, and slobbering: Yes () No ()

Were other animals exposed to saliva?: Yes () No () Unknown ()

Animal Control notified Yes () No () Additional Notes/details: _____

Please send or Fax completed report to: Grant County Health District
PO Box 37
Ephrata, WA. 98823
FAX: (509) 754-0941

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(For office use only)

Date received at Health District: _____
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By: _____