

# Summit County Public Health

1867 W. Market St. Akron, OH 44313

Phone: (330)926-5600

Fax: (330)923-6436

## ANIMAL BITE / EXPOSURE REPORT

**Ohio Administrative Code 3701-3-28 requires:** Whenever a person is bitten by a dog or other mammal, report of such bite shall be made within **twenty-four (24) hours** to the health commissioner of the district in which such bite occurred...

**COMPLETE AND FAX TO (330)923-6436 OR EMAIL TO [rabies@schd.org](mailto:rabies@schd.org) WITHIN 24 HOURS**

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| <p style="text-align: center;"><b><u>VICTIM INFORMATION</u></b></p> <p>Name: _____</p> <p>Age: _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female</p> <p>Address: _____</p> <p>City: _____ Zip: _____</p> <p>Daytime Phone: _____</p> <p>Parent/Guardian: _____</p> <p>Email: _____</p><br><p style="text-align: center;"><b><u>VICTIM BITE/EXPOSURE INFORMATION</u></b></p> <p>Date: _____ Time: _____ AM/PM</p> <p>Area of Body: _____</p> <p>Occurred at: Street _____</p> <p style="padding-left: 100px;">City _____ ZIP _____</p> <p>Was this a bite? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Was the skin broken? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Did the exposure occur on the owner's property? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Circumstances: Unprovoked __ Provoked __</p> <p style="padding-left: 40px;">Playful __ Sick __ Hurt __ Vicious __</p> | <p style="text-align: center;"><b><u>ANIMAL OWNER INFORMATION</u></b></p> <p>Name: _____</p> <p>Address: _____</p> <p>City: _____ Zip: _____</p> <p>Daytime Phone: _____</p> <p>Email: _____</p><br><p style="text-align: center;"><b><u>ANIMAL INFORMATION</u></b></p> <p>Dog ___ Cat ___ Bat ___ Raccoon ___</p> <p>Ferret ___ Skunk ___ Rodent ___ Coyote ___</p> <p>Fox ___ Livestock ___ Other _____</p> <p>Name of Animal: _____</p> <p>Breed: _____ Gender: M/F</p> <p>Color/Markings: _____</p> <p>Condition of Animal: Well __ Sick __ Dead __</p> <p>Animal retained by: _____</p><br><p style="text-align: center;"><b><u>ANIMAL VACCINATION INFORMATION</u></b></p> <p>Date of Rabies Vaccination: ___/___/___</p> <p>Tag #: _____ 1 yr __ 3 yr __</p> <p>Vaccinated by: _____</p> <p>City: _____ Zip: _____</p> |
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| <b>To Be Completed by Reporting Facility</b>  |  |
|---|--|
| Reported By: <i>(Name of Clinic / Hospital)</i>   | Contact Phone Number:  |
| Medical Treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Date of treatment: ___/___/___   | Treatment Provided By: <i>(Physician's Name)</i>   |
| Type of Injury: <input type="checkbox"/> Bite <input type="checkbox"/> Other Exposure<br>Was Skin Broken: <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes: <input type="checkbox"/> Puncture <input type="checkbox"/> Scratch<br><input type="checkbox"/> Abrasion <input type="checkbox"/> Laceration | Anatomical Location of Injury(ies):<br><br>Rabies Post Exposure Treatment Started:<br><input type="checkbox"/> Yes <input type="checkbox"/> No |