ANIMAL BITE REPORT FORM

Florida Administrative Code (FAC) 64D-3.002(1)(a), Communicable Diseases, requires that any animal bite to a human by a potentially rabid animal or nonhuman primate, be reported to the local county health department within 72 hours of recognition. To facilitate this process, the required information on this form may be faxed to **DOH-Manatee** at **(941) 750-9364**.

PATIENT INFORMATION

Date of Bite/Exposure: ____________________ **Patient Date of Birth:** ________
Name of Patient: ____________________________________ **Weight:** _____ **lbs.**
Address: ______________________________________ **Race:** _____ **Sex:** ☐ **M** ☐ **F**
City: ______________________________ **State:** _____ **Zip:** ____________
Phone: (H) ___________________ **(W)** _________________________
Parent Name and Phone (if minor): ____

Type of Exposure: ☐ **Bite** ☐ **Scratch** ☐ **Other:** ____________________
Skin Broken: ☐ **Yes** ☐ **No** **Drew Blood:** ☐ **Yes** ☐ **No**
Location of Wound(s): ____
Location and Circumstances of Incident: _________________________________
____
Treatment Provided: ☐ **Yes** ☐ **No** **If Yes, describe:** ___________________
(Tetanus, Antibiotics, bandages, stitches, etc.)

ANIMAL INFORMATION

Location of Animal (if known): ____
Type of Animal: ☐ **Dog** ☐ **Cat** ☐ **Other:** __________________
Description: Breed: ________________ **Color:** __________ **Sex:** ☐ **M** ☐ **F** ☐ **Unk**
Animal's Name (or other descriptor, such as kennel #) _______________________
Manatee County License Tag: ☐ **Yes** ☐ **No** ☐ **Unknown**
If Yes, Tag # and Year: ____
Rabies Vaccination Current: ☐ **Yes** ☐ **No** ☐ **Unknown**
If Yes, Date of Vaccination: ________________ **By:** _______________
Quarantined: ☐ **Yes** ☐ **No** ☐ **Unknown**
If Yes, Where: ____

ANIMAL OWNER INFORMATION

Name of Owner: ______________________ **Phone: (H)** ____________ **(W)** ___________
Owner Address: _______________________ **City/St:** ________________ **Zip:** ______

REPORTED BY: _______________________ **Clinic Name:** _____________________