



# Animal Bite Report Form

Epidemiology, Disease Control and Immunization Services (EDC-IS)  
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The Florida Administrative Code Chapter 64D-3 requires that animal bites to humans by a potentially rabid animal be reported to the health department next business day of the event.

Date of Report: _____
Reporting Agency: _____
Person completing Form: _____
Telephone: _____

## A. Person Bitten (Victim)

Name (Last, First):	DOB:	Age:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female, pregnant? <input type="radio"/> No <input type="radio"/> Yes
Race: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Other <input type="checkbox"/> Unknown	Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> UNK		
Address:	City:	State:	Zip:
Telephone:	Other telephone/email:		
Parent/Guardian name (if victim is minor):	Insurance: <input type="checkbox"/> No <input type="checkbox"/> Yes, name:	<input type="checkbox"/> UNK	
Medicaid: <input type="checkbox"/> No <input type="checkbox"/> Yes			
Victim relationship to animal: <input type="checkbox"/> No relation <input type="checkbox"/> Occupational <input type="checkbox"/> Owner <input type="checkbox"/> UNK			
Place of attack:	Time and date of attack:		
Circumstances of attack: <input type="checkbox"/> Playful <input type="checkbox"/> Provoked <input type="checkbox"/> Sick/Hurt <input type="checkbox"/> K-9 (Police Action) <input type="checkbox"/> Unknown <input type="checkbox"/> Other:			
Type of exposure: <input type="checkbox"/> Bite <input type="checkbox"/> Scratch <input type="checkbox"/> Saliva to mucus membrane or open cuts <input type="checkbox"/> handling/contact <input type="checkbox"/> Other:			
Wound(s) location: <input type="checkbox"/> Eyes <input type="checkbox"/> Face <input type="checkbox"/> Head <input type="checkbox"/> Mouth <input type="checkbox"/> Neck <input type="checkbox"/> Arm <input type="checkbox"/> Hand <input type="checkbox"/> Abdomen <input type="checkbox"/> Leg <input type="checkbox"/> Torso/Trunk/Chest <input type="checkbox"/> Other:			
<u>Wound care Information</u>		<u>Anti-Rabies Post-Exposure Prophylaxis (PEP)</u>	
Patient washed wound? <input type="checkbox"/> No <input type="checkbox"/> Yes, how long after exposure: _____		<i>Note: raccoon, fox, bats or if animal not found PEP is recommended</i>	
Physician: saw patient on (date): _____		Recommended? <input type="checkbox"/> No <input type="checkbox"/> Yes	
washed/flushed wound? <input type="checkbox"/> No <input type="checkbox"/> Yes		If yes, by whom: _____	
gave tetanus prophylaxis? <input type="checkbox"/> No <input type="checkbox"/> Yes		Initiated? <input type="checkbox"/> No <input type="checkbox"/> Yes, date: _____	
gave antibiotics? <input type="checkbox"/> No <input type="checkbox"/> Yes		If yes, which one? <input type="radio"/> RIG (Immunoglobulin)	
sutured wound? <input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="radio"/> Rabies Vaccine	
provided other treatment? _____			
ER visit? <input type="checkbox"/> No <input type="checkbox"/> Yes		Hospitalized? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Comments/Notes:			

## B. Animal Information

Type of animal: <input type="checkbox"/> Dog <input type="checkbox"/> Cat <input type="checkbox"/> Other:	Description (breed, color, etc.):		
Animal was: <input type="checkbox"/> Owned <input type="checkbox"/> Stray <input type="checkbox"/> Wild <input type="checkbox"/> UNK	Behavior: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> UNK		
Animal owner name (custodian):	Telephone:		
Address:	City:	State:	Zip:
Animal ever vaccinated against rabies? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> UNK If yes, vaccinated by: <input type="checkbox"/> Owner <input type="checkbox"/> Vet <input type="checkbox"/> UNK			

### Health Department use only:

- Case # \_\_\_\_\_
- Incident reported to animal services control?  No  Yes, date: \_\_\_\_\_
- Animal vaccinated?
  - No
  - Yes, type of vaccine:  1<sup>st</sup> vaccine  1-year  3-year  UNK  other: \_\_\_\_\_ Recent vaccination date: \_\_\_\_\_