



# ANIMAL BITE/EXPOSURE REPORT FORM

Victim's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Parent's Name: \_\_\_\_\_ (If victim is minor child)

Address: \_\_\_\_\_

Phone (H): \_\_\_\_\_ (C): \_\_\_\_\_

Owner's Name: \_\_\_\_\_ Phone (H): \_\_\_\_\_ (C): \_\_\_\_\_

Address: \_\_\_\_\_

Type of Animal: \_\_\_\_\_ Is the Animal:  Pet  Stray  Wildlife Biting History:  Yes  No

Name of Pet: \_\_\_\_\_ Breed: \_\_\_\_\_ Color: \_\_\_\_\_  Male  Female

Age: \_\_\_\_\_ Date of Rabies Vaccination: \_\_\_\_\_

Is the animal licensed in Delaware County:  Yes  No  Unknown If yes, Tag # and year: \_\_\_\_\_

Veterinary Information: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of Incident: \_\_\_\_\_  Bite  Scratch  Other Location of wound(s): \_\_\_\_\_

Skin broken:  Yes  No Was there blood:  Yes  No

Where did the incident occur: \_\_\_\_\_

Briefly describe what happened:

Date of Treatment: \_\_\_\_\_ Facility Where Treated: \_\_\_\_\_

Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Type of Treatment:  Wound Cleansed  Antibiotic  Tetanus  Sutures  Other: \_\_\_\_\_

Post Exposure Prophylaxis (PEP):  Yes  No

Person's Name Completing Form: \_\_\_\_\_ Phone: \_\_\_\_\_

### REPORTING INFORMATION

Animal Bites MUST be reported by telephone, email, or FAX within 24 hours

Phone: (484) 276-2100

FAX: (484) 534-5660

Email: AnimalReporting@co.delaware.pa.us