



YAKIMA HEALTH DISTRICT
 1210 Ahtanum Ridge Drive
 Union Gap WA 98903
 509.249.6504

ANIMAL BITE REPORT

FAX WITHIN 24 HOURS TO:
 (509) 249-6604

IMPORTANT: FILL IN FORM AS COMPLETELY AS POSSIBLE

Does Victim Parent Owner speak Spanish only?

VICTIM INFORMATION

Last Name _____ First Name _____ MI _____ DOB ____/____/____ Age ____ Sex: M F
 Address _____ City _____ State ____ Zip _____
 Home phone (____) _____ - _____ Work Phone (____) _____ - _____ Cell Phone (____) _____ - _____
 Occupation _____ Employer _____
 If victim under 18: Parent/Guardian Name _____ Phone (____) _____ - _____
 Address _____ City _____ State ____ Zip _____
 School Name _____ City _____ Grade _____
 Has victim had rabies vaccination (min. 3 doses) in past? Y N Unk Total Doses: _____ Last Dose ____/____/____
 Has victim received a Tetanus shot in the last 5 years? Y N Unk Most recent tetanus shot ____/____/____

BITE INFORMATION

Date of bite ____/____/____ What happened to cause bite? _____

 Where did bite occur (e.g. home, work, etc) _____
 Site of bite wound (e.g. head, hand, leg) _____
 Was the skin broken? Y N Unk Was the wound cleaned? Y N Unk If yes, at: Home Health Facility
 Who was notified? Doctor or other healthcare provider Animal Control, District Name _____
 Police, Case # _____ Other _____
 If Doctor or Healthcare Provider seen: Name of Clinic or Hospital _____
 Doctor Name _____ Phone Number (____) _____ - _____

ANIMAL AND OWNER INFORMATION

ANIMAL INFORMATION: (do not use this form for rabbit or rodent bites)

Type: Bat Cat Dog Ferret Raccoon Other _____ Size: S M L
 Ownership: Stray Wild Domestic → If domestic animal, name _____ Sex: M F Unk
 Breed _____ Color _____ Disposition: Healthy Sick died, date: ____/____/____ Unk
 If sick, symptoms: Paralyzed Drooling Confused Thirsty Aggressive Agitated Other _____
 Born in U.S.? Y N Unk Traveled out of country in last 6 mos.? Y N Unk Where? _____
 Animal rabies vaccination status: Vaccinated Vaccination not current Never been vaccinated Unknown
 Rabies vaccination within last 3 years? Y No Unk Most recent (mo/yr) ____/____ Total doses ____
 Animal Clinic Name _____ City _____ Phone (____) _____ - _____

OWNER INFORMATION:

Name _____ Phone (____) _____ - _____
 Street Address _____ City _____ State ____ Zip _____
 Mailing Address _____ City _____ State ____ Zip _____

YHD USE ONLY: Rec'd ____/____/____ From _____ Fax Verbal Mail-PM ____/____/____
 Investigator _____ PHIMS:# _____ - _____ - _____ Ent ____/____/____ Comp ____/____/____ RFMI? N Y ____/____/____
 NOQ ____/____/____ Mail Verbal NOQR ____/____/____ Mail Verbal Other LHJ? N Y→LHJ _____ Not. ____/____/____