

Stark County Rabies Advisory Council

Animal Bite Report Form

Alliance City, Canton City, Massillon City, and Stark County Health Departments

(or Similar Exposures)

ANIMAL INFORMATION

Species: <input type="checkbox"/> Dog <input type="checkbox"/> Cat <input type="checkbox"/> Bat <input type="checkbox"/> Skunk <input type="checkbox"/> Raccoon <input type="checkbox"/> Coyote <input type="checkbox"/> Other: _____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown Check if Stray <input type="checkbox"/>	Description of Animal: Breed _____ Size _____ Color _____ Markings _____ Name _____	Animal Owner Name: (If no known owner, please write "STRAY")
		Animal Owner Address: <input type="checkbox"/> Check if Unknown	
		Animal Owner Phone Number:	

Geographical Location / Address:
(Township / City / Area in which the Bite / Exposure occurred?)

If bite / exposure occurred in Alliance City , it would be reported to: Alliance City Health Dept. Fax # 330-821-9517 Phone # 330-821-7373	If bite / exposure occurred in Canton City , it would be reported to: Canton City Health Dept. Fax # 330-489-3335 Phone # 330-489-3327	If bite / exposure occurred in Massillon City , it would be reported to: Massillon City Health Dept. Fax # 330-830-1798 Phone # 330-830-1711	If bite / exposure occurred in any other location in Stark County , it would be reported to: Stark County Health Dept. Fax # 330-493-9920 Phone # 330-493-9904
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VICTIM INFORMATION

Victim Name: (Please Print Clearly)	Date of Exposure / Bite:	
Victim Address w/ Zip:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Age:
Parent / Guardian Name: (If Victim is a Minor)	Relationship: (To Victim)	
Parent / Guardian Address: (If different from Victim)	Phone # _____ <input type="checkbox"/> Victim <input type="checkbox"/> Parent / Guardian	

MEDICAL PERSONNEL USE ONLY

Reported By: (Name of Clinic / Hospital)		Contact Phone #
Medical Treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No	Treatment Provided By: (Physician's Name)	Date of Treatment:
Type of Injury: <input type="checkbox"/> Bite <input type="checkbox"/> Other Exposure Was Skin Broken: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes: <input type="checkbox"/> Puncture <input type="checkbox"/> Scratch <input type="checkbox"/> Abrasion <input type="checkbox"/> Laceration	Anatomical Location of Injury(ies): _____ Rabies Post Exposure Treatment Started: <input type="checkbox"/> Yes <input type="checkbox"/> No	

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FORM INSTRUCTIONS

The purpose of this form is to notify the local health department of a potential rabies exposure. This report is required by section 3701-3-28 of the Ohio Administrative Code. This section requires that a report of an animal bite be made to the Health Commissioner of the jurisdiction where the bite occurred within 24 hours of the bite in the same manner as the reporting of class A diseases. Completing and faxing this form fulfills that obligation. If you have any questions completing this form, please contact one of the health departments listed on the front of this form using the phone numbers provided.

ANIMAL INFORMATION

Species, Sex, Description: Enter the species, sex, and a brief description (color, size, etc.) of the subject animal in this section. Complete this section with as much information as available at the time of treatment. If the animal is unowned, check the box for 'Stray'.

Animal Owner Name, Address, and Phone Number: Complete this information with the animal owner's name, address, and phone number as reported by the victim. Accurate information is important to be able to identify the animal and place the animal under quarantine. Questionable information should be verified with the telephone book or other reference material.

Geographical Information: Enter the political jurisdiction in which the bite / exposure occurred in this area (i.e. city or township locality). This is critical for proper notification to the correct local health department with jurisdiction for action. In many cases, this may be the political jurisdiction where the animal owner lives. If you do not know the exact jurisdiction, please check with the telephone book or other reference material and enter your best estimate. The local health department will correct this information and forward the information to the correct health department as necessary.

VICTIM INFORMATION

Victim Name and Information: Enter the name and address of the victim in this area. Accurate information is critical for proper notification to the appropriate health department. Please verify questionable information with the telephone book or other reference information. If the victim is a minor, please indicate the information for the parent or guardian, including the relationship of the parent or guardian and associated address.

Date of Exposure / Bite: Enter the date of the animal bite or exposure as reported by the victim.

Victim Gender and Age: Enter the victim's sex and age in this area.

MEDICAL PERSONNEL USE ONLY

Reported By: Enter the name, organization, and telephone number of the individual making this report. This section is reserved for use by medical personnel.

Medical Treatment, Treatment Provided By, and Date of Treatment: Enter "Yes" if medical treatment was provided as a result of this animal bite. If treatment was provided, indicate the treating physician and the date treatment was provided.

Type of Injury: Indicate a brief description of the injury and the location of the injury(ies) on the victim's body.

Rabies Post Exposure Treatment: Please indicate whether rabies post exposure treatment has been started.

NOTIFICATION

The Ohio Administrative Code requires that notification of an animal bite be made to the Health Commissioner within 24 hours after exposure. Faxing this completed form to one of the health departments listed on the front of this form fulfills this obligation. **Please review the notice for accuracy and completeness and then fax** this completed form to the appropriate agency as soon as possible after providing any necessary treatment.