ANIMAL BITE REPORT

OWNER OF ANIMAL
CH ID ______
Name: ____________________________
Street Address: ____________________
City: _____________________________ Zip: ________
Tel: Home ________ Work ________

PERSON BITTEN
CH ID ______
Name: ____________________________ DOB: ___ / ___ / ___
Street Address: ____________________
City: _____________________________ Zip: ________
Tel: Home ________ Work ________

ANIMAL
Species: □ Dog □ Cat □ Other: ____________________________
Name of Animal: ____________________________
Age: ________ Breed: ____________________ Color: __________
Sex: □ Male □ Female □ Altered □ Unknown
Was: □ Leashed □ Fenced □ Loose □ Unknown
Current Rabies Shot? □ Yes □ No □ Unknown

ANIMAL MEDICAL CARE OBTAINED? □ Yes □ No □ Unknown
If yes, complete the following: Date of Visit __________________
Physician: ____________________________ Physician’s Tel: __________

MEDICAL CARE OBTAINED?

EXPLAIN CIRCUMSTANCES OF BITE INCIDENT OR ANY PREVIOUS BITE INCIDENT:
____________________________________________________________________________________________________________________________________________________________

BELOW TO BE FILLED OUT BY ANIMAL SHELTER

Date Quarantined: ___________________ By: ________________
□ Home □ Shelter □ Other: ____________________________
Other Address: ____________________________
City: ____________________________ Tel: __________
Animal No.: ____________ Kennel No.: ____________
License No.: ____________ Expiration: ____________

Date Released: ________________ By: ____________
Quarantine Failure: □ Reason: ____________________________
Rabies Specimen to Health Department □
Delivered by: ____________________________ Date: ____________
Rabies Vaccine Mfr: ____________ Expiration: ____________
Given by: ____________________________ Lot/ Tag No.: ____________
Condition of Animal Upon Release: ____________________________

I, the undersigned owner or person having control of the animal described in this Animal Quarantine/Bite Report, received and understand the requirements of this quarantine and will notify the PENINSULA HUMANE SOCIETY & SPCA immediately should the described animal become sick, injured, lost or die during the designated time period. In addition, I understand that I will be invoiced a quarantine fee of $60 per SM County Ordinance 6.04.290.

SIGNATURE: ____________________________ DATE: ____________

Return Form to:
Peninsula Humane Society & SPCA
12 Airport Boulevard
San Mateo, CA 94401
Tel (650) 340-8200
Fax (650) 685-0102

OFFICERS’ COMMENTS, CONTACTS AND ACTIVITIES ON BACK OF FORM

DATE OF BITE
DUE DATE OUT
DATE RELEASED
RELEASED BY

OFFICIAL USE ONLY
BITE REPORT NO.

FRA Result ______ FRA Test Date ______ PH Staff Initials ______

Revised January 2024