

PLEASE PRINT



STATE LAW REQUIRES
COMPLETED FORM TO BE
IMMEDIATELY FAXED TO:
(650) 685-0102

ANIMAL BITE REPORT

Reporting Facility / Person: _____ Date Reported: _____

Address: _____ Tel: _____

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: <input type="checkbox"/> Dog <input type="checkbox"/> Cat <input type="checkbox"/> Other: _____
Name of Animal: _____
Age: _____ Breed: _____ Color: _____
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Altered <input type="checkbox"/> Unknown
Was: <input type="checkbox"/> Leashed <input type="checkbox"/> Fenced <input type="checkbox"/> Loose
Current Rabies Shot? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

BITE
Address or place where bite occurred: _____

Date Bitten: _____ Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM
Where on body bitten: _____
Skin broken? <input type="checkbox"/> Yes <input type="checkbox"/> No

MEDICAL CARE OBTAINED? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete the following: _____ Date of Visit _____
Physician: _____ Physician's Tel: _____

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

BELOW TO BE FILLED OUT BY ANIMAL SHELTER

Date Quarantined: _____ By: _____
<input type="checkbox"/> Home <input type="checkbox"/> Shelter <input type="checkbox"/> Other: _____
Other Address: _____

City: _____ Tel: _____
Animal No.: _____ Kennel No.: _____
License No.: _____ Expiration: _____

Date Released: _____ By: _____
Quarantine Failure: <input type="checkbox"/> Reason: _____
Rabies Specimen to Health Department <input type="checkbox"/>
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 \$50 per SM County Ordinance 6.04.290.

SIGNATURE: _____ DATE: _____

OFFICERS' COMMENTS, CONTACTS AND ACTIVITIES ON BACK OF FORM

Return Form to: Peninsula Humane Society & SPCA 12 Airport Boulevard San Mateo, CA 94401 Tel (650) 340-8200 Fax (650) 685-0102	DATE OF BITE	OFFICIAL USE ONLY BITE REPORT NO. _____ _____ FRA Result _____ FRA Test Date _____ PH Staff Initials _____
	DUE DATE OUT	
	DATE RELEASED	
	RELEASED BY	

ALL OR PORTIONS OF THIS FORM MAY BE DISCLOSED UNDER THE CA PUBLIC RECORDS ACT 6250-6276.48.

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