



ANIMAL BITE/EXPOSURE REPORTING FORM

9880 Murray Ridge Road, Elyria, Ohio 44035
PHONE: (440) 322-6367 FAX: (440) 322-6010

**Lorain County
Public Health**

For the Health of Us All

**Per Ohio Law, all animal bites must be reported to the health department.
Please fax form within 24 hours to Lorain County Public Health at 440-322-6010**

Please complete this form fully. For the protection of the victim, Lorain County Public Health works with the animal owner to verify the animal's current rabies vaccination status. LCPH does not remove animals from their homes or label them as vicious. Please Note: Victims of "Stray or Unknown Owner" animal bites may need post-exposure rabies vaccinations

Victim Name:		Age:	Date of Birth:
Address:	City:	State:	Zip:
Phone:		Email Address:	
Parent/Guardian Name (if minor):		Relationship to Victim:	
Type of Exposure: <input type="checkbox"/> Bite <input type="checkbox"/> Scratch <input type="checkbox"/> Other, please describe: Was the skin broken: <input type="checkbox"/> Yes <input type="checkbox"/> No		Location of exposure on body:	
Other human exposures: <input type="checkbox"/> Yes <input type="checkbox"/> No Pet exposure(s): <input type="checkbox"/> Yes <input type="checkbox"/> No		Was the bite provoked? <input type="checkbox"/> Yes <input type="checkbox"/> No (Provoked means teased, tormented, or abused)	
Date of Bite/Exposure:	Date Reported:	Reported By:	
Medical Treatment By:	Phone:	Rabies Prophylaxis Administered? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Animal Owner Name:	Phone:	Email Address:	
Address:	City:	State:	Zip:
Type of Animal: <input type="checkbox"/> Dog <input type="checkbox"/> Cat <input type="checkbox"/> Bat <input type="checkbox"/> Raccoon <input type="checkbox"/> Skunk <input type="checkbox"/> Opossum <input type="checkbox"/> Other, describe:	Description of Animal (if known): Breed _____ Color _____ Markings _____	Pet's Name: Pet's Age: Pet's Sex:	<input type="checkbox"/> Pet <input type="checkbox"/> Stray <input type="checkbox"/> Wild <input type="checkbox"/> Unknown
Veterinary Clinic:	Address:	Phone:	
Rabies Vaccination Date: <input type="checkbox"/> 1 year vaccine <input type="checkbox"/> 3 year vaccine	Rabies Tag #:	Vaccine Due Date:	

Additional Comments:
