



**REPORT OF ANIMAL BITE/EXPOSURE**  
 (Complete a separate form for each person)

**REPORT INFORMATION IMMEDIATELY TO:**  
**CLINTON COUNTY HEALTH DEPARTMENT - ENVIRONMENTAL HEALTH & SAFETY DIVISION**  
 133 Margaret Street, Plattsburgh, NY 12901  
 (518) 565-4870 (Phone) / (518) 565-4843 (Fax)

Information Taken By \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

**PERSON BITTEN/EXPOSED** \_\_\_\_\_ D.O.B. \_\_\_\_\_ Parent's Name \_\_\_\_\_

Mailing Address \_\_\_\_\_

Phone \_\_\_\_\_ Bus. Phone \_\_\_\_\_ Message Phone \_\_\_\_\_

**BITE/EXPOSURE DATE** \_\_\_\_\_ Town Where Bite/Exp. Occurred \_\_\_\_\_

Body part bitten/exposed \_\_\_\_\_

How bite/exposure occurred \_\_\_\_\_

Was animal showing unusual behavior? No \_\_\_\_\_ Yes \_\_\_\_\_

Attending MD \_\_\_\_\_ Hospital/Clinic \_\_\_\_\_ Phone \_\_\_\_\_

Primary MD \_\_\_\_\_ Health Ins. Co. \_\_\_\_\_ I.D. NO. \_\_\_\_\_

**ANIMAL DATA**

**SPECIES** \_\_\_\_\_ Breed \_\_\_\_\_ Sex \_\_\_\_\_

Description \_\_\_\_\_ Name \_\_\_\_\_

Owner \_\_\_\_\_ Phone \_\_\_\_\_ Bus. Phone \_\_\_\_\_

Owner Mailing Address \_\_\_\_\_

Animal is: \_\_\_\_\_ Domestic \_\_\_\_\_ Stray \_\_\_\_\_ Wild

Status: \_\_\_\_\_ Alive \_\_\_\_\_ Dead If Killed, Date \_\_\_\_\_

Means \_\_\_\_\_

Date of last rabies vaccination \_\_\_\_\_ Vet \_\_\_\_\_

Is rabies known or suspected to be present in species & area? \_\_\_\_\_ Yes \_\_\_\_\_ No

Comments: \_\_\_\_\_



**FOR HEALTH DEPARTMENT USE ONLY**

PATIENT NAME \_\_\_\_\_ CDESS # \_\_\_\_\_

**ANIMAL CONFINEMENT & VACCINATION STATUS**

	Yes	No	Initials	Date
Alive, Well & Available for 10-Day Confinement?				
Current Rabies Vacc. At Time of Bite?				
Confinement Explained to _____ (Responsible Adult)				
Confinement Letter Sent*(attach copy)				
To be Confined at ___ Home OR ___ Approved facility:				
Delivered to Facility on _____ (Date)				
Alive and Well After 10 Day Conf. ( ___ / ___ / _____ )				
OK Given to Release From Conf. Facility?				
Vaccination Given After 10 Day Conf.?				
If no Vaccination, R-Letter Sent (attach copy)				
IF Not Sent, Give Reason: _____				

**ANIMAL TESTING**

Vet Office Handling Specimen:			Phone:		
Specimen Sent To Rabies Lab?	NO _____	Yes _____	Sent By _____	Carrier _____	Date _____
Test Results	NEG _____	POS _____	UNSAT _____	LAB NO. _____	Date _____
Patient Notified of Results?			By _____	Date _____	
Veterinarian or Other Interested Party Notified?			By _____	Date _____	

**HUMAN POST EXPOSURE TREATMENT**

	Initials	Date
Treatment Authorized		
Monthly Log Entry Completed		
CDESS Entry Completed		
CDESS Printout attached		
Copy of Paperwork to 'Intake RN', H.C.S. Division		
Notification E-mail to H.C.S. Division Supervising RN's (attach copy)		
CVPH Medical Center Emergency Department Notified		

List Other Persons Possibly exposed to Same Animal:

_____	_____
_____	_____
_____	_____

**DOMESTIC ANIMAL EXPOSED TO RABID OR SUSPECT RABID ANIMAL**

Owner Questioned By: \_\_\_\_\_ Date \_\_\_\_\_  
 Exposure Occurred: Yes \_\_\_\_\_ No \_\_\_\_\_  
 "DISPOSITION OF ANIMALS" Form Completed By \_\_\_\_\_ Date \_\_\_\_\_