City of Middletown Health Department
Animal Bite Intake Report

To be completed by the Treating Facility

Facility Name:		Physician:
Address:		City:
State:	Zip:	Phone:
Rabies Post Exposure Treatment Started: YES ☐ NO ☐		

Victim (please provide as much information as possible)

Date of Injury:		Location of Injury:
Incident Address/Location:		
Circumstances of Incident:		
Victim Name:	Email:	
Address:	Phone:	
City:	State:	
Parent/Guardian *(if victim is a minor)*:		Phone:
Parent/Guardian Address *(if different than above)*:		

Animal (please provide as much information as possible)

Animal: DOG ☐ CAT ☐ BAT ☐ OTHER:		Stray/Wild: YES☐ NO☐
Animal Name:	Breed:	Color:
Owner Name:	Owner Address:	
City:	State:	Zip:
Owner Phone:	Owner Email:	
Rabies Vaccination: YES ☐ NO: ☐ DON'T KNOW ☐		Vaccination Tag#:
Veterinarian:	Veterinarian Address:	
City:	State:	Zip:
Location of Animal: OWNER'S HOME☐ ANIMAL SHELTER☐ OTHER:		

Additional Comments
