



**CITY OF SAN ANTONIO  
ANIMAL BITE EXPOSURE REPORT**



4710 State Hwy 151 San Antonio, Texas 78227  
Office Phone- 210-207-6667, 210-207-6668/ Fax- 210-207-6678  
Hours of Operation: Mon-Fri- 11 AM to 7 PM; Sat- 11 AM to 5 PM; Sun- Closed  
www.sanantonio.gov/animalcare / www.saac.net

As required by Texas Administrative Code, Title 25, Part 1, Chapter 97, Subchapter A, Rule 97.3, and in accordance with Sec. 5-126 of the City of San Antonio ordinance the following requested information is required by law to be reported.  
**PRINT ALL INFORMATION CLEARLY. FAX A COPY OF THIS REPORT TO: Animal Care Services at 210-207-6678 AND The San Antonio Metropolitan Health District at 210-207-2839.**

DATE OF INCIDENT: \_\_\_\_/\_\_\_\_/\_\_\_\_ TIME: \_\_\_\_\_ AM/PM

LOCATION (ADDRESS) OF INCIDENT: \_\_\_\_\_

INCIDENT OCCURRED:      ON PROPERTY                            OFF PROPERTY        
EXPOSURE:                      ANIMAL TO HUMAN                            ANIMAL TO ANIMAL     

**VICTIM INFORMATION**

VICTIM'S NAME: \_\_\_\_\_ PARENTS NAME (IF MINOR): \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY/STATE/ZIP: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_ ALTERNATE PHONE NUMBER: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_      AGE: \_\_\_\_\_      SEX: M  F  UNKNOWN

INJURED BODY PART: \_\_\_\_\_

(HEAD, NECK, ARM, LEG, ETC.)

SEVERITY OF INJURY: MILD       MODERATE                       SEVERE

TYPE OF INJURY: PUNCTURE       LACERATION                       SCRATCH                       OTHER: \_\_\_\_\_

BRIEF DETAILS OF THE INCIDENT (ATTACH PHOTOS IF POSSIBLE): \_\_\_\_\_

OWNER IDENTIFIED                       (OR) STRAY

IDENTIFIED OWNER NAME: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_ ALTERNATE PHONE NUMBER: \_\_\_\_\_

ALLEGED BITING ANIMAL DESCRIPTION:

SPECIES & BREED: \_\_\_\_\_ COLOR & MARKINGS: \_\_\_\_\_

SEX: M  F  UNKNOWN       PROOF OF CURRENT VACCINATION: YES  NO  UNKNOWN

**CARE PROVIDERS**

IF YOU ARE THE CARE PROVIDER PLEASE CHECK ALL APPROPRIATE BOXES BELOW:

1. PATIENT ASSESSMENT INDICATED NO NEED FOR RABIES PEP

2. WOUNDS TREATED

3. POST-EXPOSURE PROPHYLAXIS INITIATED

A. HRIG.      DATE: \_\_\_\_\_ DOSE # \_\_\_\_\_ LOT#: \_\_\_\_\_ MANUFACTURER: \_\_\_\_\_

B. VACCINE. DATE: \_\_\_\_\_ DOSE # \_\_\_\_\_ LOT#: \_\_\_\_\_ MANUFACTURER: \_\_\_\_\_

NAME OF CARE PROVIDER: \_\_\_\_\_

PROVIDER'S PHONE NUMBER: \_\_\_\_\_

**CLINIC OR FACILITY**

FORM COMPLETED BY: \_\_\_\_\_ DATE & TIME: \_\_\_\_\_

FACILITY: \_\_\_\_\_ PHONE #: \_\_\_\_\_ FAX #: \_\_\_\_\_