Rabies Post Exposure Vaccination Documentation

Name:		
Date of Birth:	**Gender:** ☐ **Male** ☐ **Female**	
Address:		
City:	**State:** ☐ **AZ**	**Zipcode:**
Telephone:	**Telephone:**	
County:		
Type of animal exposed to:		
Animal control contact information:		
Type of exposure: ☐ **Bite** ☐ **Mucous Membrane Contact with Saliva** ☐ **Other:**		

Date of exposure:

Treatment Schedule	Treatment Needed	Injection site	Treatment Date	Provider Signature
Day 0	rabies immune globulin			
Day 0	Rabies vaccine			
Day 3	Rabies vaccine only			
Day 7	Rabies vaccine only			
Day 14	Rabies vaccine only			
Day 28	Rabies vaccine only *(immunocompromised patients)*			

Provider Information

Name	Address	City, State, Zip	Telephone

If you have questions, please contact the Arizona Department of Health Services at (602) 364-4562.

When vaccination series is complete, please submit this form to:

Arizona Department of Health Services- Office of Infectious Disease- Vector-Borne & Zoonotic Diseases
150 N. 18th Avenue, Suite 140 Phoenix, Arizona 85007-3237
Fax: (602) 364-3198 Email: vbzd@azdhs.gov