



Ohio Department of Health
Bureau of Environmental Health and Radiation Protection
 246 N. High St., Columbus, OH 43215
 Phone (614) 644-7438, Fax (614) 466-4556, Email BEH@odh.ohio.gov

LHD Name: _____

PUBLIC POOL AND SPA INJURY INCIDENT REPORT FORM

Please use one form for each injured person. DO NOT include their personal information (e.g., name, address, phone number, etc.).
 Should a reportable incident occur, complete the form, attach all required documentation, and submit to the local health district as stipulated.

- Within 24 hours of an injury, drowning, near drowning, or suction entrapment occurring at a pool or spa that results in death or requires resuscitation transfer/admission to a hospital;
- Within 72 hours of the owner's/operator's knowledge of the incident; and
- Every 3 months during operation or at the facility's season closure, a water rescue by aquatic safety personnel.

ATTN: Local Health Districts: Submit reports via mail, fax, or email to the address, fax number, or email indicated at the top of this form.
 Please direct questions to **(614) 644-7438**.

FACILITY INFORMATION			
Facility Name:		Facility Address:	
City:	State:	ZIP:	Facility Phone:
Facility Type: <input type="checkbox"/> Govt/City Pool <input type="checkbox"/> Apartment/Condo <input type="checkbox"/> Hotel/Motel <input type="checkbox"/> Manufactured/Mobile Home Park <input type="checkbox"/> School <input type="checkbox"/> Camp <input type="checkbox"/> Other: _____			
DESCRIPTION OF INJURED PERSON			
Age (years):	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Resident County:	
Race (check all that apply): <input type="checkbox"/> White/Caucasian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other: _____		Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino	Was injured party: <input type="checkbox"/> Employee <input type="checkbox"/> Patron <input type="checkbox"/> Other: _____
DESCRIPTION OF INCIDENT			
Incident Date (mm/dd/yy):	Time of day: ___ : ___ : ___ <input type="checkbox"/> AM <input type="checkbox"/> PM	Day of week incident occurred: <input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thurs <input type="checkbox"/> Fri <input type="checkbox"/> Sat	
What happened? (attach additional sheets, if needed):		Location of Incident (check all that apply): <input type="checkbox"/> Outdoor Facility <input type="checkbox"/> Indoor Facility <input type="checkbox"/> Main Pool <input type="checkbox"/> Wading Pool <input type="checkbox"/> Zero Entry Pool <input type="checkbox"/> Therapy Pool <input type="checkbox"/> Spa/Hot Tub <input type="checkbox"/> Diving Board <input type="checkbox"/> Slide <input type="checkbox"/> Spray Ground/Splash Pad <input type="checkbox"/> Other Water Feature: _____	
Was the pool/spa open at time of the incident? <input type="checkbox"/> Yes <input type="checkbox"/> No Was the enclosure secured? <input type="checkbox"/> Yes <input type="checkbox"/> No	Were lifeguards present? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A # Lifeguards present: _____	Water depth of incident: _____ (ft.) _____ (in.)	Number of swimmers/witnesses present during the incident: _____
Result of Incident: Was there a water rescue? <input type="checkbox"/> Yes <input type="checkbox"/> No Was rescue breathing/resuscitation required? <input type="checkbox"/> Yes <input type="checkbox"/> No Was the Heimlich Maneuver required? <input type="checkbox"/> Yes <input type="checkbox"/> No Was the person immobilized? <input type="checkbox"/> Yes <input type="checkbox"/> No Was an AED Device used? <input type="checkbox"/> Yes <input type="checkbox"/> No Was oxygen supplied? <input type="checkbox"/> Yes <input type="checkbox"/> No		Was EMS called? <input type="checkbox"/> Yes <input type="checkbox"/> No Did staff provide care or first-aid? <input type="checkbox"/> Yes <input type="checkbox"/> No Did injured person refuse care or first-aid? <input type="checkbox"/> Yes <input type="checkbox"/> No Did injured person return to water activity? <input type="checkbox"/> Yes <input type="checkbox"/> No Was injured person transported to a medical facility? <input type="checkbox"/> Yes <input type="checkbox"/> No	
DESCRIPTION OF INJURY		Rescue Equipment Used: <input type="checkbox"/> Rescue Can <input type="checkbox"/> Rescue Tube <input type="checkbox"/> Ring Buoy <input type="checkbox"/> Life Hook/Shepherd's Crook <input type="checkbox"/> Other: _____ <input type="checkbox"/> N/A	
Type of Injury: <input type="checkbox"/> Burn <input type="checkbox"/> Bump/Bruise <input type="checkbox"/> Cut <input type="checkbox"/> Puncture <input type="checkbox"/> Scrape <input type="checkbox"/> Dislocation <input type="checkbox"/> Sprain <input type="checkbox"/> Fracture <input type="checkbox"/> Spinal <input type="checkbox"/> Near Drowning <input type="checkbox"/> Suffocation/Drowning <input type="checkbox"/> Other: _____		<div style="display: flex; justify-content: space-around;"> <div style="text-align: center;"> <p>Front</p> </div> <div style="text-align: center;"> <p>Back</p> </div> </div>	
Area Injured: <input type="checkbox"/> Head/Neck <input type="checkbox"/> Arm/Shoulder <input type="checkbox"/> Leg/Hip/Knee <input type="checkbox"/> Trunk/Torso <input type="checkbox"/> Face/Eyes <input type="checkbox"/> Hand/Wrist <input type="checkbox"/> Foot/Ankle <input type="checkbox"/> Back <input type="checkbox"/> Other: _____			
FORM COMPLETED BY			
Name (print):		Contact Phone:	
Position (e.g. pool operator, lifeguard, etc.):		Date:	