

Public Pool and Spa Injury Incident Report Form



Local Health District Name: _____

Please use one form for each injured person. DO NOT include their personal information (e.g., name, address, phone number, etc.).

- In accordance with OAC 3701-31-04(B)(4)(a)(x) any incident that occurs within the pool perimeter that results in death, serious injury, assistance from emergency medical personnel or an illness involving more than one person will be reported to the licensor **within seventy-two hours following the incident** or when the licensee becomes aware of the incident.
- In accordance with OAC 3701-31-03(l) the licensor will forward information received from the pool operator regarding incidents that occur at the public swimming pool to the Ohio Department of Health **within thirty days of receipt** of the report.

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 (Do NOT include personal information (e.g., name, address, phone number, etc.))			
Age (years)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	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 <input type="checkbox"/> Native Hawaiian/ Pacific <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 the 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 the time of the incident? <input type="checkbox"/> Y <input type="checkbox"/> N Was the enclosure secured? <input type="checkbox"/> Y <input type="checkbox"/> N	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 incident: _____
Result of Incident Was there a water rescue? <input type="checkbox"/> Y <input type="checkbox"/> N Was rescue breathing/resuscitation required? <input type="checkbox"/> Y <input type="checkbox"/> N Was the Heimlich Maneuver required? <input type="checkbox"/> Y <input type="checkbox"/> N Was the person immobilized? <input type="checkbox"/> Y <input type="checkbox"/> N Was an AED Device used? <input type="checkbox"/> Y <input type="checkbox"/> N Was oxygen supplied? <input type="checkbox"/> Y <input type="checkbox"/> N		Rescue Equipment Used <input type="checkbox"/> Rescue Can <input type="checkbox"/> Rescue Tube <input type="checkbox"/> Ring Buoy <input type="checkbox"/> Life Hook/Shepard's Crook <input type="checkbox"/> Other: _____ <input type="checkbox"/> N/A	

Description of Incident			
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-between;"> Front Back </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 MUST BE COMPLETED / REVIEWED BY POOL OPERATOR: (The pool operator or representative should complete this information and return completed form to the Local Health District)			
Name (print)		Contact Phone	
Position (e.g. pool operator, lifeguard, etc.)		Date	

Local Health District Use Only
 Submit reports to ODH through the electronic submission form. Please direct questions to (614) 644-7438.
 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