INJURY / ILLNESS REPORT

State Form 46347 (R3 / 3-18)
INDIANA STATE DEPARTMENT OF HEALTH

Instructions:
Mail or fax form to:

Indiana State Department of Health
Environmental Public Health Division
100 North Senate Avenue, Room N855
Indianapolis, Indiana 46204
317/233-7811, Fax: 317/233-7047

Rule 410 IAC 6-2.1 requires that for each occurrence that: results in death, requires resuscitation, results in transportation to a hospital or other facility for medical treatment, or results in an illness connected to the water quality at the pool be reported to the department within ten (10) days.

Please Print All Information.

Facility Information

Name of Facility	Facility Identification Number
Street Address, City, State, ZIP Code	County
Contact Person *(First, Last Name)*	Telephone Number
Operator on Duty *(First, Last Name)*	Certified Pool Operator ☐ Yes ☐ No

Description of Incident

Date of Injury / Illness *(mm/dd/yy)*		Time of Day
Name of Person Affected *(First, Middle Initial, Last Name)*	Sex ☐ M ☐ F	Date of Birth (*mm/dd/yy*)
Street Address, City, State, ZIP Code		Telephone Number
Attending Physician *(First, Middle Initial, Last Name)*		Telephone Number

Was Facility Open for Swimming? ☐ Yes ☐ No	Was Resuscitation Required? ☐ Yes ☐ No	If Yes, then Performed by:	AED Device Used? ☐ Yes ☐ No
Result of Incident ☐ Died ☐ Hospitalized ☐ Treated and released		If Death, Cause of Death:	Lifeguard Present? ☐ Yes ☐ No

How did injury Illness Occur? (*attach additional sheets if needed*):

Description of Injury

Type of Injury:
☐ Burn ☐ Concussion ☐ Cut / Puncture ☐ Dislocation ☐ Fracture ☐ Suffocation / Drowning ☐ Near Drowning
☐ Spinal Injury ☐ Other – *Specify*:

Area Injured (when other than Drowning or Near Drowning): ☐ Arm / Shoulder ☐ Back ☐ Face / Eyes ☐ Foot / Ankle ☐ Hand / Wrist
☐ Head / Neck ☐ Leg / Hip / Knee ☐ Respiratory System ☐ Trunk

Where Did Injury Occur?
☐ In Pool or Spa ☐ Deck / Walkway ☐ Locker Room ☐ Diving Board ☐ Water Slide
☐ Other – *Specify*:

Description of Illness

Date of Onset of Symptoms *(mm/dd/yy)*	Number of Persons Affected:

Symptoms (*check all that apply*):
☐ Cramps ☐ Dermatitis ☐ Diarrhea (≥ 3 stools / Day) ☐ Diarrhea – Other – *Specify Definition:*
☐ Visible Blood in Stool ☐ Ear Infection ☐ Fever ☐ Nausea ☐ Respiratory Symptoms ☐ Strep Throat ☐ Rash ☐ Vomiting
☐ Other – *Specify*:

Signature: _____ Date: *(mm/dd/yy)*_____