



# FIREWORKS INJURY REPORTING

State Form 51497 (R5 / 3-14)  
INDIANA STATE DEPARTMENT OF HEALTH

**CONFIDENTIAL INFORMATION**

- INSTRUCTIONS:** 1. Print information to ensure legibility.  
 2. Fill in circles for appropriate choice.  
 3. Complete all items on the forms.  
 4. Per HEA 1131, report must be completed within five (5) business days after examination of the injury.

## Section 1: Demographic Information on Injured Person

Date of Medical Evaluation (mm/dd/yy): \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Telephone Number: ( ) - \_\_\_\_\_ Date of birth (mm/dd/yy): \_\_\_\_\_ Age: \_\_\_\_\_

If child, name of parent or guardian (Last, First, MI): \_\_\_\_\_

Street Address: \_\_\_\_\_

City / Town: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_ County: \_\_\_\_\_

Sex:	Race (choose all that apply)	Ethnicity
<input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Unknown	<input type="radio"/> White <input type="radio"/> Black or African American <input type="radio"/> Asian <input type="radio"/> Native Hawaiian or Other Pacific Islander <input type="radio"/> American Indian or Alaska Native <input type="radio"/> Multiracial <input type="radio"/> Unknown	<input type="radio"/> Hispanic or Latino <input type="radio"/> Not Hispanic or Latino

## Section 2—Site of Report: Hospital / Emergency Department / Physician Office / Surgical Center

Hospital Name: \_\_\_\_\_

Hospital / Related Site:                       Emergency Department                       Urgent Care Center

Ambulatory Surgical Center (Name): \_\_\_\_\_

If reporting from a Health Care Provider Office, State Name of Practice: \_\_\_\_\_

Physician Name: \_\_\_\_\_

Contact through:                       Email: \_\_\_\_\_                       Office: ( ) - \_\_\_\_\_

Street Address: \_\_\_\_\_

City / Town: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_ County: \_\_\_\_\_

<b>(Person Reporting) Title:</b> _____	
Last Name: _____	First Name: _____
Telephone Number: ( ) - _____	Email: _____

Name of Injured Person: \_\_\_\_\_

<b>Section 3: Injury and Surrounding Circumstances</b>	
<b>Body Part Involved (note all involved)</b>	<b>Type of Injury (note all involved)</b>
<input type="checkbox"/> Hand(s) / Finger <input type="checkbox"/> Arm <input type="checkbox"/> Eye(s) <input type="checkbox"/> Face / Ears / Head <input type="checkbox"/> Leg(s) / Foot / Toe(s) <input type="checkbox"/> Trunk <input type="checkbox"/> Other  _____	<input type="checkbox"/> Burn <input type="checkbox"/> 1 <sup>st</sup> Degree <input type="checkbox"/> 2 <sup>nd</sup> Degree <input type="checkbox"/> 3 <sup>rd</sup> Degree <input type="checkbox"/> Contusion / Laceration / Abrasion <input type="checkbox"/> Puncture Wound <input type="checkbox"/> Penetrating Foreign Body / Missile <input type="checkbox"/> Sprain / Fracture <input type="checkbox"/> Other  _____
<b>Outcome (note all that apply)</b>	<b>Circumstances of Injury</b>
<input type="checkbox"/> Death <input type="checkbox"/> Evaluated in Emergency Department <input type="checkbox"/> Released to home <input type="checkbox"/> Admitted to hospital <input type="checkbox"/> Transferred to  _____ <input type="checkbox"/> Evaluated in provider office <input type="checkbox"/> Released to home <input type="checkbox"/> Admitted to hospital  <input type="checkbox"/> Other (Specify) <b>If hospitalized:</b> Date of admission (mm/dd/yy): _____ Date of discharge (mm/dd/yy): _____ (if available)	Date of injury (mm/dd/yy): _____ Time of injury: _____ o AM   o PM  <u>Locale of injury:</u> <input type="checkbox"/> <b>Private</b> home / yard / property <input type="checkbox"/> Friend / neighbor / relative home / yard / property <input type="checkbox"/> <b>Public</b> park / street / property <input type="checkbox"/> School property <input type="checkbox"/> Other (Specify) _____  <b>If eye injury:</b> <input type="checkbox"/> No eye protection <input type="checkbox"/> Eyeglasses or safety glasses  <input type="checkbox"/> Contact lenses
<b>Risk Factors at the time of injury</b>	<b>Type of Fireworks / Pyrotechnics</b>
<input type="checkbox"/> Alcohol Consumption <input type="checkbox"/> By injured person <input type="checkbox"/> Within three (3) hours of injury <input type="checkbox"/> Blood alcohol tested <input type="checkbox"/> Unknown <input type="checkbox"/> By other people at the scene <input type="checkbox"/> If injured person is less than eighteen (18) years of age, was an adult present? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown  <input type="checkbox"/> Injured person was a bystander	<input type="checkbox"/> Firecrackers <input type="checkbox"/> Rockets (i.e., bottle rockets) <input type="checkbox"/> Sparklers <input type="checkbox"/> Twisters / "Jumping Jacks" <input type="checkbox"/> Lighting gunpowder <input type="checkbox"/> Homemade, altered device <input type="checkbox"/> Aerial devices <input type="checkbox"/> Other (fountains, roman candles, etc.)  _____ <input type="checkbox"/> Pyrotechnics (indoor fireworks event) – <i>Specify Event or Location involved</i>  _____ <input type="checkbox"/> Unspecified / Unknown
<b>Mechanism / Problem (if known)</b>	<b>Comments / Additional Information</b>
<input type="checkbox"/> Malfunction / timing of firework <input type="checkbox"/> Errant path of rocket <input type="checkbox"/> Debris from aerial fireworks <input type="checkbox"/> Mishandling (relighting, throwing, etc.) <input type="checkbox"/> Other <input type="checkbox"/> Unknown	          

**Please fax this form to (317) 233-8199: Attn: Injury Epidemiologist**  
**Or mail to: Indiana State Dept of Health**  
**2 North Meridian Street**  
**Indianapolis, IN 46204**  
**Please direct any questions to (317) 233-7716**