Reset Form

# INJURY / ILLNESS REPORT

State Form 46347 (R4 / 2-23)
INDIANA DEPARTMENT OF HEALTH

**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)*_____