



INJURY / ILLNESS REPORT

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

Instructions:
Mail or fax form to:

Indiana Department of Health
Environmental Public Health Division
2 North Meridian Street, 7-D
Indianapolis, Indiana 46204
317/233-7177, 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 <input type="checkbox"/> Yes <input type="checkbox"/> No

Description of Incident

Date of Injury / Illness (mm/dd/yy)		Time of Day	
Name of Person Affected (First, Middle Initial, Last Name)		Sex <input type="checkbox"/> M <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was Resuscitation Required? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, then Performed by:	AED Device Used? <input type="checkbox"/> Yes <input type="checkbox"/> No
Result of Incident <input type="checkbox"/> Died <input type="checkbox"/> Hospitalized <input type="checkbox"/> Treated and released		If Death, Cause of Death:	Lifeguard Present? <input type="checkbox"/> Yes <input type="checkbox"/> 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:
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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) _____