



**KCMO HEALTH DEPARTMENT
ENVIRONMENTAL PUBLIC HEALTH**
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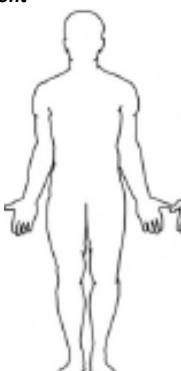



Public Health

PUBLIC POOL AND SPA INJURY INCIDENT REPORT FORM

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

Should a reportable incident occur, complete the form, attach all required documentation, and submit to the KCMO Health Department within 24 hours of an injury, drowning, near drowning, or suction entrapment occurring at a pool or spa that results in death or requires resuscitation transfer/admission to a hospital.

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			
Age (years):	Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other	Resident County:	Was injured party: <input type="checkbox"/> Employee <input type="checkbox"/> Patron <input type="checkbox"/> Other: _____
DESCRIPTION OF INCIDENT			
Incident Date (mm/dd/yyyy):	Time of day: _____ : _____ <input type="checkbox"/> AM <input type="checkbox"/> PM	Day of 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 time of the incident? <input type="checkbox"/> Yes <input type="checkbox"/> No Was the enclosure secured? <input type="checkbox"/> Yes <input type="checkbox"/> No	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 the incident:
Result of Incident: Was there a water rescue? <input type="checkbox"/> Yes <input type="checkbox"/> No Was rescue breathing/resuscitation required? <input type="checkbox"/> Yes <input type="checkbox"/> No Was the Heimlich Maneuver required? <input type="checkbox"/> Yes <input type="checkbox"/> No Was the person immobilized? <input type="checkbox"/> Yes <input type="checkbox"/> No Was an AED Device used? <input type="checkbox"/> Yes <input type="checkbox"/> No Was oxygen supplied? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was EMS called? <input type="checkbox"/> Yes <input type="checkbox"/> No Did staff provide care or first-aid? <input type="checkbox"/> Yes <input type="checkbox"/> No Did injured person refuse care or first-aid? <input type="checkbox"/> Yes <input type="checkbox"/> No Did injured person return to water activity? <input type="checkbox"/> Yes <input type="checkbox"/> No Was injured person transported to a medical facility? <input type="checkbox"/> Yes <input type="checkbox"/> No	Rescue Equipment Used: <input type="checkbox"/> Rescue Can <input type="checkbox"/> Rescue Tube <input type="checkbox"/> Ring Buoy <input type="checkbox"/> Life Hook/Shepherd's Crook <input type="checkbox"/> Other: _____ <input type="checkbox"/> N/A	
DESCRIPTION OF INJURY			
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-around;"> <div style="text-align: center;"> <p>Front</p>  </div> <div style="text-align: center;"> <p>Back</p>  </div> </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 COMPLETED BY			
Name (print):	Contact Phone:		
Title (e.g. pool operator, lifeguard, etc.):	Date:		

OFFICE USE ONLY	
Permit #: _____	Rec'd by: _____ Date: _____