



2017 Ohio Public Swimming Pool and Spa Injury Report Training

Sean-Paul Albert Claypool, MPH
CDC/CSTE Applied Epidemiology Fellow
Ohio Department of Health

Outline

- Background
- New in 2017
- General guidance
- Report form walkthrough
- Report submission workflow
- Demo
- Questions

BACKGROUND

Background

- Drowning is the leading cause of unintentional injury deaths in children ages 1 to 4 in Ohio
 - Second leading cause in children ages 5 to 9 and 10 to 14
- Survivors of severe drowning incidents can experience long-term disabilities including
 - Memory problems
 - Learning deficiencies
 - Loss of basic cognitive functioning

Background (cont.)

- To date, Ohio has not systematically collected detailed information on public swimming pool-related injuries or deaths
- Drowning Prevention Pilot Project was launched in 2015 to determine the frequency and circumstances of these occurrences
- Between 2015 and 2016, ODH received more than 300 injury reports voluntarily submitted by participating local health departments

OAC 3701-31: “Public Swimming Pools”

Rule No. 3701-31-04: “Responsibilities of the licensee”

Draft §(B)(4)(a)(x): “All injuries shall be recorded as they happen. **Any incident** associated with the pool facility that results in **death, serious injury, assistance from emergency medical personnel** or an illness involving more than one person shall be reported to the licensor on a form prescribed by the director of health within seventy-two hours following the incident. As used in this paragraph: “serious injury” means an injury that does not require immediate hospital admission but does require medical treatment, other than first aid”.

NEW IN 2017

New in 2017

- From pilot to program
 - 2015: 23 local health districts, outdoor season only
 - 2016: 32 local health districts, outdoor season only
 - 2017: statewide, year round (draft OAC 3701-31-04)
- Redesigned form
 - De-emphasized ODH
 - Reordered sections
 - Easier to read
- Online reporting from LDH to ODH

Report Form: 2016 vs. 2017



Ohio Department of Health
Bureau of Environmental Health and Radiation Protection
246 N. High St., Columbus, OH 43215
Phone (614) 644-7438, Fax (614) 466-4556, Email BEH@odh.ohio.gov

LHD Name: _____

PUBLIC POOL AND SPA INJURY INCIDENT REPORT FORM

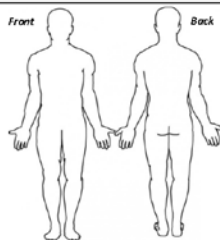
Please use one form for each injured person. **DO NOT include their personal information (e.g., name, address, phone number, etc.).**

Should a reportable incident occur, complete the form, attach all required documentation, and submit to the local health district as stipulated.

- 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;
- Within 72 hours of the owner's/operator's knowledge of the incident; and
- Every 3 months during operation or at the facility's season closure, a water rescue by aquatic safety personnel.

ATTN: Local Health Districts: Submit reports via mail, fax, or email to the address, fax number, or email indicated at the top of this form. Please direct questions to (614) 644-7438.

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	Resident County:	
Race (check all that apply): <input type="checkbox"/> White/Caucasian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other: _____			
Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Middle Eastern/North African <input type="checkbox"/> Other: _____			
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: _____ AM _____ 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		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: _____	
What happened? (attach additional sheets, if needed):		Were lifeguards present? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Was the pool/spa open at time of the incident? <input type="checkbox"/> Yes <input type="checkbox"/> No		Water depth of incident: _____ (ft.) _____ (in.)	
Was the enclosure secured? <input type="checkbox"/> Yes <input type="checkbox"/> No		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		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: _____	
DESCRIPTION OF INJURY			
Type of Injury (check all that apply): <input type="checkbox"/> Bump/Bruise <input type="checkbox"/> Scrape <input type="checkbox"/> Dislocation <input type="checkbox"/> Puncture <input type="checkbox"/> Burn <input type="checkbox"/> Drowning (Non-fatal) <input type="checkbox"/> Spinal <input type="checkbox"/> Fracture <input type="checkbox"/> Cut <input type="checkbox"/> Dislocation <input type="checkbox"/> Puncture <input type="checkbox"/> Other: _____		Area Injured (check all that apply): <input type="checkbox"/> Head/Neck <input type="checkbox"/> Arm/Shoulder <input type="checkbox"/> N/A <input type="checkbox"/> Face/Eyes <input type="checkbox"/> Hand/Wrist <input type="checkbox"/> Other: _____ <input type="checkbox"/> Trunk/Torso <input type="checkbox"/> Leg/Hip/Knee <input type="checkbox"/> Foot/Ankle <input type="checkbox"/> Back	
FORM COMPLETED BY		RESULTS OF INCIDENT	
Name (print):		Was EMS called? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Contact Phone:		Was a water rescue performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date:		Was injured person transported to a medical facility? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Position (e.g., pool operator, lifeguard, etc.):		Was the injured person immobilized? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Was oxygen supplied to the injured person? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Was an AED used? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Did injured person return to water activity? <input type="checkbox"/> Yes <input type="checkbox"/> No	
FACILITY IDENTIFICATION			
Facility Name:		Facility Address:	
City:		Zip:	
Facility Type (check one): <input type="checkbox"/> Apartment/Condo <input type="checkbox"/> Government/City Pool <input type="checkbox"/> Manufactured/Mobile Home Park		Phone:	
<input type="checkbox"/> Other: _____ <input type="checkbox"/> Camp <input type="checkbox"/> Hotel/Motel <input type="checkbox"/> School			
FORM COMPLETED BY			
Name:		Title/Position:	
Phone:		Date:	
POOL OPERATORS: SUBMIT COMPLETED FORMS TO YOUR LOCAL HEALTH DISTRICT			
To find your Local Health District: visit http://www.odh.ohio.gov/localhealthdistricts/lhddirectory .			



Ohio Public Swimming Pool and Spa Injury Report Form

Use one form for each injured person. **Do not include personal information of the injured person (e.g., name, address, phone number).** Injuries required to be reported include any incident associated with the pool facility that results in serious injury, assistance from emergency medical personnel, or death. Do not write on the back of this form.

DESCRIPTION OF THE INJURED PERSON			
Age (years):	Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	County of Residence (if not in Ohio, report state of residence):	
Race/Ethnicity (check all that apply): <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Middle Eastern/North African <input type="checkbox"/> Unknown/Decline <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other: _____			The injured person was a: <input type="checkbox"/> Patron <input type="checkbox"/> Resident <input type="checkbox"/> Other: _____
DESCRIPTION OF THE INCIDENT			
Date:	Time: _____ AM _____ PM	Incident Setting (check one): <input type="checkbox"/> Indoor <input type="checkbox"/> Outdoor	
Was pool/spa open at time of incident? <input type="checkbox"/> Yes <input type="checkbox"/> No		Location of Incident (check all that apply): <input type="checkbox"/> Diving Board/Well <input type="checkbox"/> Therapy Pool <input type="checkbox"/> Main Pool <input type="checkbox"/> Wading Pool <input type="checkbox"/> Slide <input type="checkbox"/> Zero Entry Pool <input type="checkbox"/> Spa/Hot Tub <input type="checkbox"/> Other: _____ <input type="checkbox"/> Spray Ground/Splash Pad	
Were lifeguards present? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		Were witnesses present? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, how many lifeguards were present? Qty: _____		If yes, how many witnesses were present? Qty: _____	
Water depth of incident: _____ feet _____ inches <input type="checkbox"/> N/A		Rescue Equipment Used (check all that apply): <input type="checkbox"/> Rescue Tube <input type="checkbox"/> N/A <input type="checkbox"/> Ring Buoy <input type="checkbox"/> Other: _____ <input type="checkbox"/> Shepherd's Crook	
Describe the incident (attach additional sheets as necessary):			
DESCRIPTION OF THE INJURY			
Type of Injury (check all that apply): <input type="checkbox"/> Bump/Bruise <input type="checkbox"/> Drowning (Fatal) <input type="checkbox"/> Scrape <input type="checkbox"/> Burn <input type="checkbox"/> Drowning (Non-fatal) <input type="checkbox"/> Spinal <input type="checkbox"/> Cut <input type="checkbox"/> Fracture <input type="checkbox"/> Sprain <input type="checkbox"/> Dislocation <input type="checkbox"/> Puncture <input type="checkbox"/> Other: _____		Area Injured (check all that apply): <input type="checkbox"/> Head/Neck <input type="checkbox"/> Arm/Shoulder <input type="checkbox"/> N/A <input type="checkbox"/> Face/Eyes <input type="checkbox"/> Hand/Wrist <input type="checkbox"/> Other: _____ <input type="checkbox"/> Trunk/Torso <input type="checkbox"/> Leg/Hip/Knee <input type="checkbox"/> Foot/Ankle <input type="checkbox"/> Back	
RESULTS OF INCIDENT			
Was EMS called? <input type="checkbox"/> Yes <input type="checkbox"/> No		Was a water rescue performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Was injured person transported to a medical facility? <input type="checkbox"/> Yes <input type="checkbox"/> No		Was rescue breathing/resuscitation required? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Was the injured person immobilized? <input type="checkbox"/> Yes <input type="checkbox"/> No		Did staff offer or provide care or first-aid? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Was oxygen supplied to the injured person? <input type="checkbox"/> Yes <input type="checkbox"/> No		Did injured person/guardian refuse care or first-aid? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Was an AED used? <input type="checkbox"/> Yes <input type="checkbox"/> No		Did injured person return to water activity? <input type="checkbox"/> Yes <input type="checkbox"/> No	
FACILITY IDENTIFICATION			
Facility Name:		Facility Address:	
City:		Zip:	
Facility Type (check one): <input type="checkbox"/> Apartment/Condo <input type="checkbox"/> Government/City Pool <input type="checkbox"/> Manufactured/Mobile Home Park		Phone:	
<input type="checkbox"/> Other: _____ <input type="checkbox"/> Camp <input type="checkbox"/> Hotel/Motel <input type="checkbox"/> School			
FORM COMPLETED BY			
Name:		Title/Position:	
Phone:		Date:	
POOL OPERATORS: SUBMIT COMPLETED FORMS TO YOUR LOCAL HEALTH DISTRICT			
To find your Local Health District: visit http://www.odh.ohio.gov/localhealthdistricts/lhddirectory .			

Please direct questions to BEH@odh.ohio.gov

HEA 0203 (Rev. 06/17)

2017 Report Form

Ohio Public Swimming Pool and Spa Injury Report Form

Use one form for each injured person. Do not include personal information of the injured person (e.g., name, address, phone number). Injuries required to be reported include any incident associated with the pool facility that results in serious injury, assistance from emergency medical personnel, or death. Do not write on the back of this form.

DESCRIPTION OF THE INJURED PERSON		
Age (years):	Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	County of Residence (if not in Ohio, report state of residence):
Race/Ethnicity (check all that apply): <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Middle Eastern/North African <input type="checkbox"/> Unknown/Decline <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other: _____		The injured person was a: <input type="checkbox"/> Patron <input type="checkbox"/> Resident <input type="checkbox"/> Other: _____
DESCRIPTION OF THE INCIDENT		
Date:	Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM	Incident Setting (check one): <input type="checkbox"/> Indoor <input type="checkbox"/> Outdoor
Was pool/spa open at time of incident? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, was enclosure secured? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Location of Incident (check all that apply): <input type="checkbox"/> Diving Board/Well <input type="checkbox"/> Therapy Pool <input type="checkbox"/> Main Pool <input type="checkbox"/> Wading Pool <input type="checkbox"/> Slide <input type="checkbox"/> Zero Entry Pool <input type="checkbox"/> Spa/Hot Tub <input type="checkbox"/> Other: _____ <input type="checkbox"/> Spray Ground/Splash Pad	
Were lifeguards present? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A If yes, how many lifeguards were present? Qty: _____	Rescue Equipment Used (check all that apply): <input type="checkbox"/> Rescue Tube <input type="checkbox"/> N/A <input type="checkbox"/> Ring Buoy <input type="checkbox"/> Other: _____ <input type="checkbox"/> Shepherd's Crook	
Were witnesses present? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many witnesses were present? Qty: _____	Water depth of incident: _____ feet _____ inches <input type="checkbox"/> N/A	
Describe the incident (attach additional sheets as necessary):		

2017 Report Form (cont.)

DESCRIPTION OF THE INJURY			
Type of Injury (check all that apply):		Area Injured (check all that apply):	
<input type="checkbox"/> Bump/Bruise	<input type="checkbox"/> Drowning (Fatal)	<input type="checkbox"/> Scrape	<input type="checkbox"/> Head/Neck
<input type="checkbox"/> Burn	<input type="checkbox"/> Drowning (Non-fatal)	<input type="checkbox"/> Spinal	<input type="checkbox"/> Arm/Shoulder
<input type="checkbox"/> Cut	<input type="checkbox"/> Fracture	<input type="checkbox"/> Sprain	<input type="checkbox"/> N/A
<input type="checkbox"/> Dislocation	<input type="checkbox"/> Puncture	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Face/Eyes
			<input type="checkbox"/> Hand/Wrist
			<input type="checkbox"/> Trunk/Torso
			<input type="checkbox"/> Leg/Hip/Knee
			<input type="checkbox"/> Back
			<input type="checkbox"/> Foot/Ankle
RESULTS OF INCIDENT			
Was EMS called?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Was injured person transported to a medical facility?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Was the injured person immobilized?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Was oxygen supplied to the injured person?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Was an AED used?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Was a water rescue performed?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Was rescue breathing/resuscitation required?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Did staff offer or provide care or first-aid?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Did injured person/guardian 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	
FACILITY IDENTIFICATION			
Facility Name:		Facility Address:	
City:		Zip:	Phone:
Facility Type (check one):		<input type="checkbox"/> Apartment/Condo	
<input type="checkbox"/> Other: _____		<input type="checkbox"/> Government/City Pool	
<input type="checkbox"/> Camp		<input type="checkbox"/> Hotel/Motel	
		<input type="checkbox"/> Manufactured/Mobile Home Park	
		<input type="checkbox"/> School	
FORM COMPLETED BY			
Name:	Title/Position:	Phone:	Date:
POOL OPERATORS: SUBMIT COMPLETED FORMS TO YOUR LOCAL HEALTH DISTRICT			
To find your Local Health District: visit http://www.odh.ohio.gov/localhealthdistricts/lhddirectory .			

Please direct questions to BEH@odh.ohio.gov

HEA 0203 (Rev. 06/17)

2017 Online Reporting Tool

OHIO PUBLIC SWIMMING POOL AND SPA INJURY REPORT

1

Exit Survey

DESCRIPTION OF THE INJURED PERSON

Age (years):

Sex:

Ohio County of Residence:

State of Residence:

Female

Male

Select

OH-Ohio

Race/Ethnicity (please check all that apply):

The injured person was a:

☐ American Indian/Alaskan Native
 ☐ Native Hawaiian/Pacific Islander

☐ Asian
 ☐ White

☐ Black/African American
 ☐ Unknown/Declined

☐ Hispanic/Latino
 ☐ Other

☐ Middle Eastern/North African

If Other, please define:

Patron

Other

Resident

If Other, please define:

DESCRIPTION OF THE INCIDENT

Date of Incident:

Time of Incident:

Incident Setting:

Indoor

Outdoor

Was pool/spa open at time of incident?

Location of Incident (check all that apply):

Yes

No

GENERAL GUIDANCE

General Guidance

- Injuries required to be reported include any incident associated with the facility that results in
 - Serious injury
 - Assistance from emergency medical personnel
 - Death
- Voluntary reporting of other injuries is highly encouraged

General Guidance (cont.)

- Pool operators & other aquatic personnel report injuries to the LHD via the Ohio Public Swimming Pool and Spa Injury Report Form
 - Reports to be submitted to LHD within 72 hours of injury
 - Form can be found at the ODH Public Swimming Pools Site
<http://www.odh.ohio.gov/odhprograms/eh/swim/swim1.aspx>
- LHD personnel report injuries to ODH online
 - Reports to be submitted to ODH by end of quarter in which received
 - Online reporting from LDH to ODH can be found at the ODH Local Health District Forms site
<http://www.odh.ohio.gov/odhprograms/eh/swim/poolform/LHDform.aspx>

General Guidance (cont.)

- Use one (1) form per each injured person
- **Do not** include personal or otherwise identifying information of the injured person, including but not limited to:
 - Name
 - Address
 - Phone number
- Do not write on the back of the form

General Guidance (cont.)

- For LHD personnel reporting injuries online:
 - Enter values online as they appear on the paper form
 - If a value is blank on the paper form, leave the corresponding entry on the electronic reporting form blank
 - i.e., If a Yes or No question on the form is left blank, do not select no on the electronic form

REPORT FORM WALKTHROUGH

Description of the Injured Person

DESCRIPTION OF THE INJURED PERSON		
Age (years): 18	Sex: <input type="checkbox"/> Female <input checked="" type="checkbox"/> Male	County of Residence (if not in Ohio, report state of residence): Franklin
Race/Ethnicity (check all that apply): <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Middle Eastern/North African <input checked="" type="checkbox"/> Unknown/Decline <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other: _____		The injured person was a: <input checked="" type="checkbox"/> Patron <input type="checkbox"/> Resident <input type="checkbox"/> Other: _____

DESCRIPTION OF THE INJURED PERSON

Age (years): 18

Sex:
☐ Female ☒ Male

Ohio County of Residence: Franklin County

State of Residence: OH-Ohio

Race/Ethnicity (please check all that apply):
☐ American Indian/Alaskan Native ☐ Native Hawaiian/Pacific Islander
☐ Asian ☐ White
☐ Black/African American ☒ Unknown/Declined
☐ Hispanic/Latino ☐ Other
☐ Middle Eastern/North African If Other, please define:

The injured person was a:
☒ Patron ☐ Other
☐ Resident
 If Other, please define:

Description of the Incident

Date: 05/01/17	Time: 12:00 <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM
Was pool/spa open at time of incident? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
If no, was enclosure secured? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A	
Were lifeguards present? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
If yes, how many lifeguards were present? Qty: 2	
Were witnesses present? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, how many witnesses were present? Qty: 15	
Water depth of incident: 12 feet 6 inches <input type="checkbox"/> N/A	

Date of Incident: 05/01/2017	Time of Incident: 12:00:00		
Was pool/spa open at time of incident?—			
<input checked="" type="radio"/> Yes <input type="radio"/> No			
If no, was the enclosure secured?—			
<input type="radio"/> Yes <input type="radio"/> No <input checked="" type="radio"/> N/A			
Were lifeguards present?—			
<input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A			
If yes, how many lifeguards were present? 2			
Were witnesses present?—			
<input checked="" type="radio"/> Yes <input type="radio"/> No			
If yes, how many witnesses were present? 15			
Water depth of incident:—			
Feet 12	Inches 6	<input type="checkbox"/> N/A	Depth (ft) 12.5

Description of the Incident (cont.)

Incident Setting (check one): ☐ Indoor ☒ Outdoor

Location of Incident (check all that apply):

☐ Diving Board/Well ☐ Therapy Pool

☒ Main Pool ☐ Wading Pool

☐ Slide ☐ Zero Entry Pool

☐ Spa/Hot Tub ☐ Other: _____

☐ Spray Ground/Splash Pad

Rescue Equipment Used (check all that apply):

☐ Rescue Tube ☒ N/A

☐ Ring Buoy ☐ Other: _____

☐ Shepherd's Crook

Incident Setting: _____

☐ Indoor ☒ Outdoor

Location of Incident (check all that apply): _____

☐ Diving Board/Well ☐ Therapy Pool

☒ Main Pool ☐ Wading Pool

☐ Slide ☐ Zero Entry Pool

☐ Spa/Hot Tub ☐ Other

☐ Spray Ground/Splash Pad

If Other, please define: _____

Rescue Equipment Used (check all that apply): _____

☐ Rescue Tube ☒ N/A

☐ Ring Buoy ☐ Other

☐ Shepherd's Crook

If Other, please define: _____

Description of the Incident (cont.)

Describe the incident (attach additional sheets as necessary): The injured person slipped along the edge of the pool, hit head, fell in, and struggled to get to the surface. Lifeguard performed water rescue.

Briefly describe the incident:

The injured person slipped along the edge of the pool, hit head, fell in, and struggled to get to the surface. Lifeguard performed water rescue.

Description of the Injury

DESCRIPTION OF THE INJURY

Type of Injury (check all that apply):

- | | | |
|---|--|---------------------------------------|
| <input checked="" type="checkbox"/> Bump/Bruise | <input type="checkbox"/> Drowning (Fatal) | <input type="checkbox"/> Scrape |
| <input type="checkbox"/> Burn | <input checked="" type="checkbox"/> Drowning (Non-fatal) | <input type="checkbox"/> Spinal |
| <input type="checkbox"/> Cut | <input type="checkbox"/> Fracture | <input type="checkbox"/> Sprain |
| <input type="checkbox"/> Dislocation | <input type="checkbox"/> Puncture | <input type="checkbox"/> Other: _____ |

Area Injured (check all that apply):

- | | | |
|---|---------------------------------------|---------------------------------------|
| <input checked="" type="checkbox"/> Head/Neck | <input type="checkbox"/> Arm/Shoulder | <input type="checkbox"/> N/A |
| <input type="checkbox"/> Face/Eyes | <input type="checkbox"/> Hand/Wrist | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Trunk/Torso | <input type="checkbox"/> Leg/Hip/Knee | |
| <input type="checkbox"/> Back | <input type="checkbox"/> Foot/Ankle | |

DESCRIPTION OF THE INJURY

Type of Injury (check all that apply):

- | | |
|--|-----------------------------------|
| <input checked="" type="checkbox"/> Bump/Bruise | <input type="checkbox"/> Puncture |
| <input type="checkbox"/> Burn | <input type="checkbox"/> Scrape |
| <input type="checkbox"/> Cut | <input type="checkbox"/> Spinal |
| <input type="checkbox"/> Dislocation | <input type="checkbox"/> Sprain |
| <input type="checkbox"/> Fracture | <input type="checkbox"/> Other |
| <input type="checkbox"/> Drowning (Fatal) | If Other, please define: _____ |
| <input checked="" type="checkbox"/> Drowning (Non-fatal) | _____ |

Area Injured (check all that apply):

- | | |
|---|---------------------------------------|
| <input checked="" type="checkbox"/> Head/Neck | <input type="checkbox"/> Leg/Hip/Knee |
| <input type="checkbox"/> Face/Eyes | <input type="checkbox"/> Foot/Ankle |
| <input type="checkbox"/> Trunk/Torso | <input type="checkbox"/> N/A |
| <input type="checkbox"/> Back | <input type="checkbox"/> Other |
| <input type="checkbox"/> Arm/Shoulder | If Other, please define: _____ |
| <input type="checkbox"/> Hand/Wrist | _____ |

Description of the Injury (cont.)

- **Bump/Bruise:** a wound resulting in a raised area of the skin or skin discoloration.
- **Burn:** an injury to the skin caused by heat, chemicals, friction or electricity.
- **Cut:** a break in the surface of the skin that may extend into the muscle tissue below.
- **Dislocation:** an injury in which the bones in a joint are forced out of their usual positions.
- **Drowning (Fatal):** respiratory impairment from submersion in liquid followed by rapid death or death within 24 hours of the incident.
- **Drowning (Non-fatal):** respiratory impairment from submersion in liquid with permanent or non-permanent injury.
- **Fracture:** a broken bone.
- **Puncture:** a wound caused by an object piercing the skin.
- **Scrape:** a skin wound that rubs or tears off skin.
- **Spinal:** an injury to the spinal cord that results in lost or impaired functioning.
- **Sprain:** an injury to a ligament (tissue that connects two or more bones at a joint).

Description of the Injury (cont.)

- **Bump/Bruise:** a wound resulting in a raised area of the skin or skin discoloration.
- **Burn:** an injury to the skin caused by heat, chemicals, friction or electricity.
- **Cut:** a break in the surface of the skin that may extend into the muscle tissue below.
- **Dislocation:** an injury in which the bones in a joint are forced out of their usual positions.
- **Drowning (Fatal):** respiratory impairment from submersion in liquid followed by rapid death or death within 24 hours of the incident.
- **Drowning (Non-fatal):** respiratory impairment from submersion in liquid with permanent or non-permanent injury.
- **Fracture:** a broken bone.
- **Puncture:** a wound caused by an object piercing the skin.
- **Scrape:** a skin wound that rubs or tears off skin.
- **Spinal:** an injury to the spinal cord that results in lost or impaired functioning.
- **Sprain:** an injury to a ligament (tissue that connects two or more bones at a joint).

Results of the Incident

RESULTS OF INCIDENT

Was EMS called? ☐ Yes ☒ No

Was injured person transported to a medical facility? ☐ Yes ☒ No

Was the injured person immobilized? ☐ Yes ☒ No

Was oxygen supplied to the injured person? ☐ Yes ☒ No

Was an AED used? ☐ Yes ☒ No

Was a water rescue performed? ☒ Yes ☐ No

Was rescue breathing/resuscitation required? ☐ Yes ☒ No

Did staff offer or provide care or first-aid? ☒ Yes ☐ No

Did injured person/guardian refuse care or first-aid? ☐ Yes ☒ No

Did injured person return to water activity? ☒ Yes ☐ No

RESULTS OF INCIDENT

Was EMS called?

☐ Yes ☒ No

Was injured person transported to a medical facility?

☐ Yes ☒ No

Was the injured person immobilized?

☐ Yes ☒ No

Was oxygen supplied to the injured person?

☐ Yes ☒ No

Was an AED Device used?

☐ Yes ☒ No

Was a water rescue performed?

☒ Yes ☐ No

Was rescue breathing/resuscitation required?

☐ Yes ☒ No

Did staff offer or provide care or first-aid?

☒ Yes ☐ No

Did injured person/guardian refuse care or first-aid?

☐ Yes ☒ No

Did injured person return to water activity?

☒ Yes ☐ No

Facility Identification

FACILITY IDENTIFICATION			
Facility Name: Facility Name		Facility Address: 123 Main St.	
City: Columbus		Zip: 43215	Phone: 555-555-5555
Facility Type (check one):	<input type="checkbox"/> Apartment/Condo	<input checked="" type="checkbox"/> Government/City Pool	<input type="checkbox"/> Manufactured/Mobile Home Park
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Camp	<input type="checkbox"/> Hotel/Motel	<input type="checkbox"/> School

FACILITY IDENTIFICATION			
Facility Name:		Facility Address:	
Facility Name		123 Main St.	
City:	Zip:	Phone (numbers only):	
Columbus	43215	5555555555	
Facility Type:			
<input type="radio"/> Apartment/Condo <input type="radio"/> Camp <input checked="" type="radio"/> Government/City Pool <input type="radio"/> Hotel/Motel		<input type="radio"/> Manufactured/Mobile Home Park <input type="radio"/> School <input type="radio"/> Other	
If Other, please define:			

Form Completed By

FORM COMPLETED BY			
Name: <i>First Last</i>	Title/Position: <i>Lifeguard</i>	Phone: <i>555-555-5555</i>	Date: <i>05/01/17</i>
POOL OPERATORS: SUBMIT COMPLETED FORMS TO YOUR LOCAL HEALTH DISTRICT			
To find your Local Health District: visit http://www.odh.ohio.gov/localhealthdistricts/lhddirectory .			

FORM COMPLETED BY			
Name		Title/Position:	
<input type="text" value="First Last"/>		<input type="text" value="Lifeguard"/>	
Phone (numbers only):		Date:	
<input type="text" value="5555555555"/>		<input type="text" value="05/01/2017"/>	

Local Health District Reporting

LOCAL HEALTH DISTRICT REPORTING

Please select the local health district to which the injury report form was submitted:

Not Listed ▼

If not listed, please enter:

ODH BEHRP Test

Name of local health district personnel entering this report:

First Last

How was the injury report form submitted to the local health district?

- ☒ Email ☐ In person ☐ Phone
☐ Fax ☐ Mail ☐ Referred from ODH

Did the local health district investigate or otherwise respond to the injury report?

- ☐ Yes ☒ No

YOU MUST CLICK "SUBMIT SURVEY" BELOW TO COMPLETE ↓↓↓



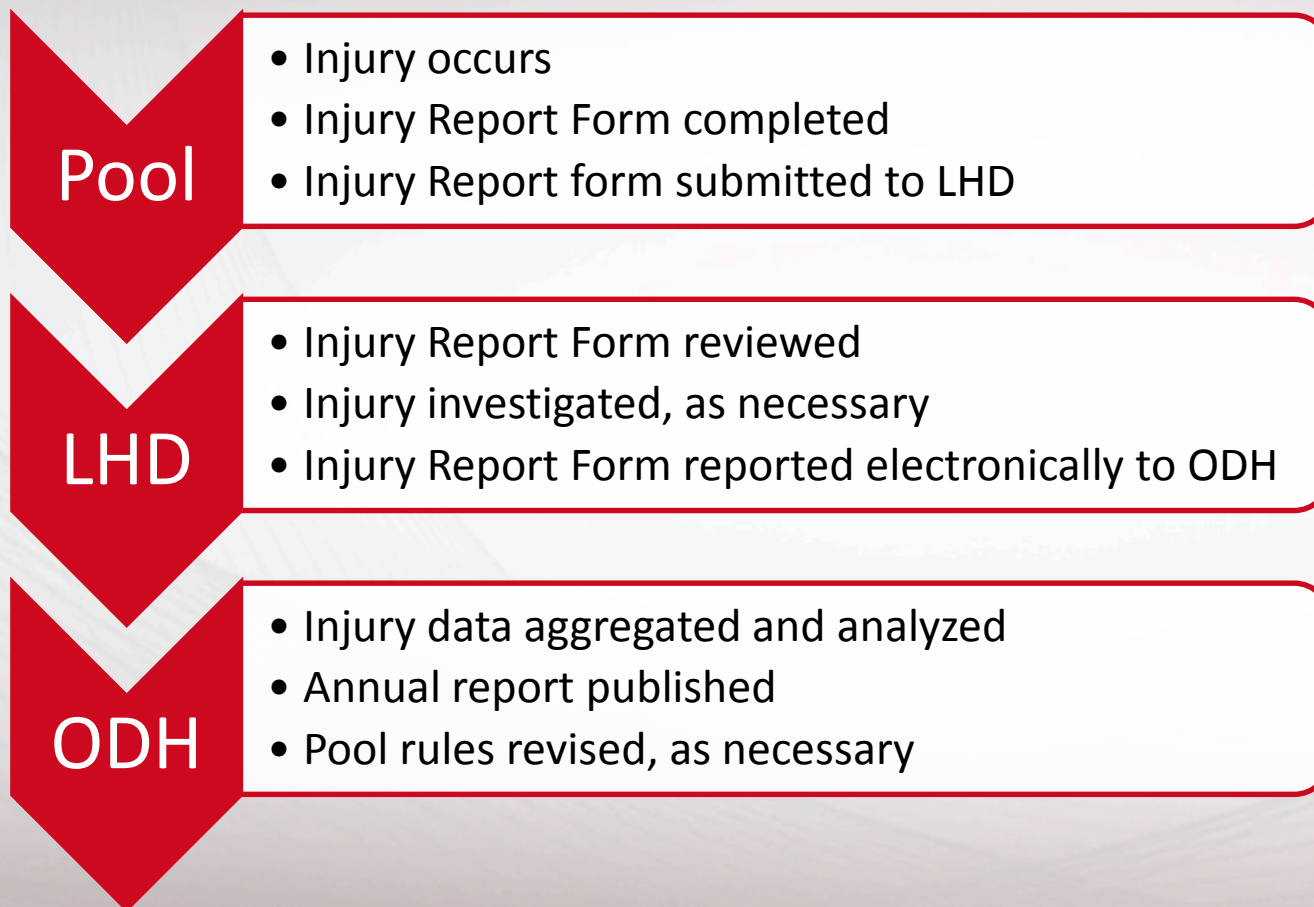
Finish later

Print

Submit Survey ✓

REPORTING FORM SUBMISSION WORKFLOW

Generalized Workflow



DEMO

Link 1 Link 2

QUESTIONS?

**PLEASE BEGIN COLLECTING REPORTS
SATURDAY, JULY 1, 2017**

Contact Information

Mary J. Clifton, RS, MA
Recreation Programs Administrator
mary.clifton@odh.ohio.gov
(614) 466-6736

Sean-Paul A. Claypool, MPH
CDC/CSTE Applied Epidemiology Fellow
sean-paul.claypool@odh.ohio.gov
(614) 752-4489

This study/report was supported in part by an appointment to the Applied Epidemiology Fellowship Program administered by the Council of State and Territorial Epidemiologists (CSTE) and funded by the Centers for Disease Control and Prevention (CDC) Cooperative Agreement Number 1U38OT000143-04.