Central Valley Health District
Environmental Health Department
Appendix D Aquatic Facility Incident Reporting Form

The aquatic facility shall ensure that a record is made of all injuries and illness incidents at the aquatic facility which:

1. Requires resuscitation, CPR, oxygen, or AED use.
2. Requires transportation of the patron to a medical facility.
3. Is a patron illness or disease outbreak associated with water quality.
4. Additionally, aquatic facilities requiring lifeguards shall also record all lifeguard rescues where the lifeguard enters the water and activates the aquatic facilities Emergency Response Plan.

Should a reportable incident occur, complete the form, attach any additional documentation, and submit it within 24 hours of the incident. Documents and questions should be sent to Central Valley Health District's Environmental Health Department.

Mail: 122 2nd Ave NW, ND 58401, Fax: 701-252-8137, Email: mabata@nd.gov, Phone: 701-252-8130

Complete one form per person involved in or affected by an incident.

FACILITY INFORMATION					
Facility name:		Address:			
City:		State:	Zip:		Phone:
INFORMATION FOR ILL/INJURED/RESCUED PERSON					
Name:		Address:			
City:		State:	Zip:		Designation of person: ☐ Employee ☐ Other *(specify)*:
DESCRIPTION OF INCIDENT					
Incident date (*mm/dd/yyyy*):	Time of day: __ __: __ __ ☐ AM ☐ PM	Location of incident *(pool, spa, deck etc.)*:			
How did the incident occur? (*attach additional sheets if needed*):					
Actions taken and equipment used (*attach additional sheets if needed*):					
Result of incident:	☐ No treatment necessary	☐ Emergency personnel contacted			
DESCRIPTION OF INJURY					
If injury includes submersion *(select all that apply)*:	☐ Suffocation /Drowning	☐ Near drowning	☐ Water Rescue	☐ Other (*specify*):	
Type of injury *(select all that apply):*	☐ Burn ☐ Concussion	☐ Cut/Puncture ☐ Sprain	☐ Fracture	☐ Spinal	☐ Other (*specify*):
Area of injury *(select all that apply):*	☐ Arm/Shoulder ☐ Back	☐ Face/Eyes ☐ Foot/Ankle	☐ Hand/Wrist ☐ Head/Neck	☐ Leg/Hip/Knee ☐ Respiratory System	☐ Trunk/Torso ☐ Other *(specify)*:
DESCRIPTION OF ILLNESS					
Date of onset of symptoms (*mm/dd/yyyy*): _____/______/______		Date Visited Aquatic Facility *(mm/dd/yyyy)*: _____/______/______			
Symptoms *(select all that apply)*:	☐ Visible blood in stool ☐ Diarrhea (*≥3 stools /day)*	☐ Vomiting ☐ Nausea ☐ Cramps	☐ Fever ☐ Respiratory symptoms	☐ Strep Throat ☐ Rash ☐ Ear Infection	☐ Other (*specify*):
STAFF RESPONDING TO THE INCIDENT (*attach additional sheets if needed*):					
Name:		Position:			
Name:		Position:			