



Central Valley Health District  
 Environmental Health Department  
**Rule 1 Aquatic Facilities**

**Appendix D 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.

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: <input type="checkbox"/> Employee <input type="checkbox"/> Other (specify): _____	
DESCRIPTION OF INCIDENT					
Incident date (mm/dd/yyyy):		Time of day: __:__:__ <input type="checkbox"/> AM <input type="checkbox"/> 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:		<input type="checkbox"/> No treatment necessary		<input type="checkbox"/> Emergency personnel contacted	
DESCRIPTION OF INJURY					
If injury includes submersion (select all that apply):	<input type="checkbox"/> Suffocation /Drowning	<input type="checkbox"/> Near drowning	<input type="checkbox"/> Water Rescue	<input type="checkbox"/> Other (specify):	
Type of injury (select all that apply):	<input type="checkbox"/> Burn <input type="checkbox"/> Concussion	<input type="checkbox"/> Cut/Puncture <input type="checkbox"/> Sprain	<input type="checkbox"/> Fracture	<input type="checkbox"/> Spinal	<input type="checkbox"/> Other (specify):
Area of injury (select all that apply):	<input type="checkbox"/> Arm/Shoulder <input type="checkbox"/> Back	<input type="checkbox"/> Face/Eyes <input type="checkbox"/> Foot/Ankle	<input type="checkbox"/> Hand/Wrist <input type="checkbox"/> Head/Neck	<input type="checkbox"/> Leg/Hip/Knee <input type="checkbox"/> Respiratory System	<input type="checkbox"/> Trunk/Torso <input type="checkbox"/> 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):	<input type="checkbox"/> Visible blood in stool <input type="checkbox"/> Diarrhea (≥3 stools per day)	<input type="checkbox"/> Vomiting <input type="checkbox"/> Nausea <input type="checkbox"/> Cramps	<input type="checkbox"/> Fever <input type="checkbox"/> Respiratory symptoms	<input type="checkbox"/> Strep Throat <input type="checkbox"/> Rash <input type="checkbox"/> Ear Infection	<input type="checkbox"/> Other (specify):
STAFF RESPONDING TO THE INCIDENT (attach additional sheets if needed):					
Name:			Position:		
Name:			Position:		