



ACHD BATHING PLACE INCIDENT REPORT FORM

3190 Sassafras Way
Pittsburgh, PA 15201
(Phone) 412-350-4046 (Fax) 412-350-2792
(Email) poolinjuryreport@alleghenycounty.onmicrosoft.com

**IMMEDIATELY CALL TO REPORT ALL DROWNINGS AND CATASTROPHIC INJURIES TO:
412.350.4046 or 412.687.ACHD**

Use this form to report all injuries/incidents involving treatment by a doctor, hospital staff, EMS, resuscitation, CPR, or use of a backboard. *Also report any water rescues.*

Facility information			
Facility Name:		Client ID#:	
Address:		Facility Phone:	
City:	State:	Zip:	Email:
Name of Registered Manager (if applicable):		Phone:	
Type of Facility: (check all that apply)			
<input type="checkbox"/> Swimming Pool	<input type="checkbox"/> Health Club	<input type="checkbox"/> Condo/HOA/Community Assoc.	
<input type="checkbox"/> Wading Pool	<input type="checkbox"/> School Pool	<input type="checkbox"/> Hotel/Motel	
<input type="checkbox"/> Spray Pad	<input type="checkbox"/> Waterslide Pool	<input type="checkbox"/> Apartment Pool	
<input type="checkbox"/> Spa/Hot Tub	<input type="checkbox"/> Diving Board/Well	<input type="checkbox"/> Other_____	
Year of pool construction: _____		<input type="checkbox"/> Indoor Pool	<input type="checkbox"/> Outdoor Pool

Incident	
Date and time of incident:	
Incident was: <input type="checkbox"/> Water Rescue/No Injury <input type="checkbox"/> Water Rescue/Injury <input type="checkbox"/> Not Water Related/Injury	
Check the BEST description of the incident: (Do not report minor cuts, scrapes, bee stings, etc.)	
<input type="checkbox"/> Fatal Drowning <input type="checkbox"/> Non-Fatal Drowning w/ permanent injury <input type="checkbox"/> Non-Fatal Drowning w/ no injury	
<input type="checkbox"/> Neck/Spinal injury <input type="checkbox"/> Cut <input type="checkbox"/> Fracture or Sprain <input type="checkbox"/> Poisoning <input type="checkbox"/> Asphyxiation <input type="checkbox"/> Other_____	
Depth of water where incident occurred:	<input type="checkbox"/> N/A (not water related)
Was a lifeguard present: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Required	If yes, # on duty at waterside:
Highest level of treatment: (check all that apply)	
<input type="checkbox"/> Treatment by lifeguard <input type="checkbox"/> Treatment by EMS	
<input type="checkbox"/> Taken to Hospital	Hospital/Physician name:_____
Injury result: <input type="checkbox"/> Recovered/No permanent injury <input type="checkbox"/> Paralysis <input type="checkbox"/> Death <input type="checkbox"/> No injury	

