



Premier Aquatics Incident Report

Person Involved in Injury or Incident: _____ Age: _____

Phone Number: _____ Guest of: _____

Address: _____

If minor, Name of Parent or Guardian: _____

Date of Incident: _____ Time of Incident: _____ AM PM

Facility Name: _____

Address of Incident: _____

Employee: YES / NO Was Security Contacted? YES / NO. Was 911 Called? YES / NO

Was injured person transported by ambulance? YES / NO

If yes, to where? _____

Type of Incident: ☐ First Aid/Injury ☐ Altercation (Verbal or Physical) ☐ Rescue

☐ Other: _____

Where in the facility did the Incident Occur? (Be Specific)

S:
Signs & Symptoms

A:
Allergies

M:
Medications

P:
Past History

L:
Last Food/Drink

E:
Events Leading Up

Type of Injury:

☐ Splinter

☐ Burn

☐ Heat Related Illness

☐ Bump/Bruise

☐ Dental Injury

☐ Head/Neck/Spinal Injury

☐ Animal Bite/Sting

☐ Stroke

☐ Choking

☐ Cut/Scrape

☐ Heart Attack

☐ Other: _____

Please phone Manager on Duty after completion of this report. Take a picture of the report and text it to the Manager on Duty



Body Part(s) Affected/Injured

	L	R		L	R
Eyes/Ears/Face	<input type="checkbox"/>	<input type="checkbox"/>	Ankles/Feet/Toes	<input type="checkbox"/>	<input type="checkbox"/>
Neck/Shoulders	<input type="checkbox"/>	<input type="checkbox"/>	Back	<input type="checkbox"/>	<input type="checkbox"/>
Arms/Elbows	<input type="checkbox"/>	<input type="checkbox"/>	Head	<input type="checkbox"/>	<input type="checkbox"/>
Hips/Legs/Knees	<input type="checkbox"/>	<input type="checkbox"/>	Internal Organs: _____		
Wrists/Hands/Fingers	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____		

Detailed account of the incident (Nature of Incident, Nature of Injury, Treatment, Times, etc.)
Please be as specific and detailed as possible. Attach additional sheets as necessary:

Employee Completing Report: _____

Date of Report: _____

Witness: _____ Phone Number: _____

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and text it to the Manager on Duty**