FIREWORKS INJURY SURVEY

Directions: Complete one survey form for each firework related injury treated by your facility. Please email them to osfminv@ks.gov or you can fax, or mail completed forms to the above address. Thank you, in advance, for your participation.

Date of Injury ______/______/______  Sex of Injured Person (Circle One): M or F  Age of Injured Person _________

A. Nature of Injury (check all that apply):

- Burns
- Trauma/Blunt Force
- Inhalation Injury/Asphyxia (Smoke)
- Complaint of Pain
- Wound/Cut/Bleeding
- Shock
- Dislocation/Fracture
- Other Injury (Specify) ______________________

B. Part of Body with Largest Percentage of Injury (check all that apply):

- Face
- Hand
- Eyes
- Leg
- Head (Not Facial Area)
- Foot
- Body/Trunk/Back/Neck
- Internal (Smoke Inhalation)
- Arm
- Other Part (Specify) ______________________

C. Type of Firework Causing Injury (check all that apply):

- Firecracker
- Mortars/Artillery
- Bottle Rocket
- Public Fireworks Display
- Sparkler
- Unknown
- Roman Candle
- Other (Specify) ______________________
- Smoke Bombs
- Homemade (Specify) ______________________

D. Activity of Injured Party (check all that apply):

- Fireworks Operator/Shooter
- Bystander Watching Fireworks
- Assisting Fireworks Operator/Shooter
- Uninvolved

E. If Injured Party was the Operator/Shooter or Assistant what was Used to Light the Firework?

- Punk
- Long Handled Lighter
- Cigarette Lighter
- Other (Specify) ______________________

F. Disposition (check that all apply):

- Admitted for Treatment
- Died
- Transfer to Burn Center
- Treated & Released
- Other (Specify) ______________________

Completed By ____________________________________  Title ________________________________  □ No Injuries to Report

Name of Facility ____________________________________________________________  □ No Injuries to Report

City of Facility _______________________________________________________________  County _________________________________

Type of Facility (Choose one):  □ Urgent Care  □ Emergency Room  □ Physician’s Office  □ Other