



FIREWORKS INJURY REPORT

NEBRASKA

Good Life. Great Safety.

STATE FIRE MARSHAL AGENCY

- Please complete this form for each fireworks-related injury treated during the study period of **June 25 to July 5**
- Enter the time the injury occurred **using the 24-hour clock**.
- Check the box next to the Type of Device causing the injury or write in a description under "other".
- In Type of Injury, check the box next to the most severe injury received or write in the injury under "other".
- In Body Part, check the next to the part of the body that sustained the severest injury or write in the body part under "other".
- Enter any additional information regarding the injury and/or a description of how the injury occurred in the Comments field.
- Please do not include any identifying information (e.g., name or date of birth) of the injured person.
- Once completed, please email form to Noelle Crew at noelle.crew@nebraska.gov.

BASIC INFORMATION			
HOSPITAL NAME:			NO INJURIES
CITY WHERE HOSPITAL LOCATED:			
CITY WHERE INJURY OCCURRED:			
DATE OF INJURY:		TIME OF INJURY:	
AGE		SEX	ACTION TAKEN
<input type="checkbox"/> 0 – 5	<input type="checkbox"/> 30 – 39	<input type="checkbox"/> Male	<input type="checkbox"/> Treated and released
<input type="checkbox"/> 6 – 10	<input type="checkbox"/> 40 – 49	<input type="checkbox"/> Female	<input type="checkbox"/> Hospitalized less than 24 hours
<input type="checkbox"/> 11 – 19	<input type="checkbox"/> 50 – 59		<input type="checkbox"/> Hospitalized more than 24 hours
<input type="checkbox"/> 20 – 29	<input type="checkbox"/> 60 – 69		<input type="checkbox"/> Other _____
TYPE OF DEVICE		REASON FOR INJURY	
<input type="checkbox"/> Artillery Shell/Mortar	<input type="checkbox"/> Parachute	<input type="checkbox"/> Device didn't go off – investigated	
<input type="checkbox"/> Bottle Rocket	<input type="checkbox"/> Party Popper	<input type="checkbox"/> Device thrown at victim	
<input type="checkbox"/> Cherry Bomb	<input type="checkbox"/> Punk	<input type="checkbox"/> Public display	
<input type="checkbox"/> Cone or Base Fountain	<input type="checkbox"/> Roman Candle	<input type="checkbox"/> Short fuse – no time to get away	
<input type="checkbox"/> Firecracker	<input type="checkbox"/> Sky Rocket	<input type="checkbox"/> Unknown	
<input type="checkbox"/> Ground Spinner/Flower	<input type="checkbox"/> Smoke Bomb	<input type="checkbox"/> Victim held device	
<input type="checkbox"/> Handle Fountain	<input type="checkbox"/> Sparkler	<input type="checkbox"/> Victim in vicinity	
<input type="checkbox"/> Homemade	<input type="checkbox"/> Unknown	<input type="checkbox"/> Other _____	
<input type="checkbox"/> M-80, etc	<input type="checkbox"/> Wheel		
<input type="checkbox"/> Missile Rocket	<input type="checkbox"/> Other _____		
TYPE OF INJURY		BODY PART INJURED	
<input type="checkbox"/> Abrasion	<input type="checkbox"/> Hearing Loss, Partial	<input type="checkbox"/> Ankle	<input type="checkbox"/> Hand
<input type="checkbox"/> Burn, 1 st Degree	<input type="checkbox"/> Hearing Loss, Total	<input type="checkbox"/> Arm	<input type="checkbox"/> Head/Face
<input type="checkbox"/> Burn, 2 nd Degree	<input type="checkbox"/> Laceration	<input type="checkbox"/> Back	<input type="checkbox"/> Leg
<input type="checkbox"/> Burn, 3 rd Degree	<input type="checkbox"/> Sight Loss, Partial	<input type="checkbox"/> Chest	<input type="checkbox"/> Neck
<input type="checkbox"/> Contusion	<input type="checkbox"/> Sight Loss, Total	<input type="checkbox"/> Ear	<input type="checkbox"/> Shoulder
<input type="checkbox"/> Dismemberment	<input type="checkbox"/> Other _____	<input type="checkbox"/> Eye	<input type="checkbox"/> Torso
<input type="checkbox"/> Fatality		<input type="checkbox"/> Finger/Thumb	<input type="checkbox"/> Wrist
<input type="checkbox"/> Fracture		<input type="checkbox"/> Foot	<input type="checkbox"/> Other _____
COMMENTS			