NEBRASKA STATE FIRE MARSHAL'S OFFICE
FIREWORKS INJURY REPORT

NEBRASKA
Good Life. Great Safety.
STATE FIRE MARSHAL OFFICE

- Please complete this form for each fireworks-related injury treated during the study period of June 25 – 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.

BASIC INFORMATION

HOSPITAL NAME: ☐ **NO INJURIES**

CITY WHERE HOSPITAL LOCATED:

CITY WHERE INJURY OCCURRED:

DATE OF INJURY: **TIME OF INJURY:**

AGE

☐ 0 – 5
☐ 6 – 10
☐ 11 – 19
☐ 20 – 29
☐ 30 – 39
☐ 40 – 49
☐ 50 – 59
☐ 60 – 69
☐ 70 – 79
☐ 80 and over

SEX

☐ Male
☐ Female

ACTION TAKEN

☐ Treated and released
☐ Hospitalized less than 24 hours
☐ Hospitalized more than 24 hours
☐ Other _____

TYPE OF DEVICE

☐ Base Fountain
☐ Bottle Rocket
☐ Cherry Bomb
☐ Cone Fountain
☐ Firecracker
☐ Ground Spinner/Flower
☐ Handle Fountain
☐ Homemade
☐ M-80, etc
☐ Missile Rocket
☐ Parachute
☐ Party Popper
☐ Punk
☐ Roman Candle
☐ Sky Rocket
☐ Smoke Bomb
☐ Sparkler
☐ Unknown
☐ Wheel
☐ Other _____

REASON FOR INJURY

☐ Device didn't go off – investigated
☐ Device thrown at victim
☐ Public display
☐ Short fuse – no time to get away
☐ Unknown
☐ Victim held device
☐ Victim in vicinity
☐ Other _____

TYPE OF INJURY (check one box only)

☐ Abrasion
☐ Burn, 1st Degree
☐ Burn, 2nd Degree
☐ Burn, 3rd Degree
☐ Contusion
☐ Dismemberment
☐ Fatality
☐ Fracture
☐ Hearing Loss, Partial
☐ Hearing Loss, Total
☐ Laceration
☐ Sight Loss, Partial
☐ Sight Loss, Total
☐ Other _____

BODY PART INJURED (check one)

☐ Ankle
☐ Arm
☐ Back
☐ Chest
☐ Ear
☐ Eye
☐ Finger/Thumb
☐ Foot
☐ Hand
☐ Head/Face
☐ Leg
☐ Neck
☐ Shoulder
☐ Torso
☐ Wrist
☐ Other _____

COMMENTS

EMAIL or FAX completed forms to:
monica.ellis@nebraska.gov
402-471-3118

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