Office of the State Fire Marshal
800 SW Jackson, Suite 104
Topeka, KS 66612-1216
Doug Jorgensen, State Fire Marshal

AD ASTRA PER ASPERA
Kansas
Office of the State Fire Marshal

Phone: (785) 296-3401
Fax: (785) 296-0151
www.firemarshal.ks.gov
Laura Kelly, Governor

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)**: U 7 **Ag of Injured Person**_______

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

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

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

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

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

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

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

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

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

- ❑ Punk
- ❑ Cigarette Lighter
- ❑ Long Handled Lighter
- ❑ Other (Specify)_____________________________

F. Disposition (check that all apply):

- ❑ Refused Treatment
- ❑ Treated & Released
- ❑ Admitted for Observation
- ❑ Admitted for Treatment
- ❑ Died
- ❑ Transfer to Burn Center
- ❑ Other (Specify) _____________________________

Completed By ____ Title _____________________________________

Name of Facility____ ❑ No Injuries to Report

City of Facility ____ County________________________________

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