

RACINE COUNTY PUBLIC HEALTH DIVISION
MONTHLY REPORT ON SWIMMING POOL OPERATION

Chapter ATCP 76 of the Wisconsin Administrative Code requires that Monthly Reports on the operation of swimming pools be submitted to the Department. The pool operator or person in charge shall fill-in the data indicated on the report as completely as possible.

Submit to the Racine County Public Health Division no later than the 10th day of the following month.

SEND REPORT TO:	Racine County Public Health Division 9531 Rayne Rd, Suite V Sturtevant, WI 53177	OR	Text: (262) 898-4495 (262) 898-4467 (262) 898-4493 (262) 898-4488	OR	Email: Charles.Dykstra@racinecounty.com Jennifer.Loizzo@racinecounty.com Kevin.Plachinski@racinecounty.com Lindsey.Visona@racinecounty.com
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Name of Pool:	Address:	Operator:										
<p>1) The following items should be checked regularly to assure that they are being properly maintained: (Place an X if equipment is on hand and properly maintained.)</p> <table border="0" style="width: 100%;"> <tr> <td><input type="checkbox"/> First Aid Kit</td> <td><input type="checkbox"/> Approved Test Kit</td> <td><input type="checkbox"/> Two (2) Blankets</td> <td><input type="checkbox"/> Handrails or Grabrails</td> <td><input type="checkbox"/> Lifeguard Chair (if applicable)</td> </tr> <tr> <td><input type="checkbox"/> Biohazard Spill Kit</td> <td><input type="checkbox"/> Shepherd's Crook or Ring Buoy</td> <td><input type="checkbox"/> Depth Markings</td> <td><input type="checkbox"/> Safety Line (if applicable)</td> <td><input type="checkbox"/> Spine Board with Straps (if applicable)</td> </tr> </table>			<input type="checkbox"/> First Aid Kit	<input type="checkbox"/> Approved Test Kit	<input type="checkbox"/> Two (2) Blankets	<input type="checkbox"/> Handrails or Grabrails	<input type="checkbox"/> Lifeguard Chair (if applicable)	<input type="checkbox"/> Biohazard Spill Kit	<input type="checkbox"/> Shepherd's Crook or Ring Buoy	<input type="checkbox"/> Depth Markings	<input type="checkbox"/> Safety Line (if applicable)	<input type="checkbox"/> Spine Board with Straps (if applicable)
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<p>2) PLEASE NOTE ANY CHANGE IN EQUIPMENT: (Please call your regional or local health department <u>before</u> installation.)</p> <p>Item _____ Manufacturer _____</p> <p>Model # _____ Installed by _____ Date _____</p>												
<p>3) Eye/respiratory Irritation, Illness or Injury? Please document type of irritation, illness or injury, date and outcome. (If EMS is called please fill out and submit Death, Injury and Illness Form to DATCP)</p> <p>_____</p> <p>_____</p>												
<p>4) Fecal Accident? Please document date of incident and response. (Complete and file the Fecal Accident Form and save for 2 years)</p> <p>_____</p> <p>_____</p>												
<p>5. Monthly Interlock Test: Document the date, results, and the name of the person performing the test.</p> <p>_____</p> <p>_____</p>												

COMMENTS:

Signature _____ Title _____ Date _____

