



DATE OF INCIDENT _____ TIME _____ <input type="checkbox"/> AM <input type="checkbox"/> PM Team/Club/Organization: _____ Address: _____ Telephone Number: _____	DOES THE INJURED PERSON HAVE OTHER MEDICAL INSURANCE? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, please provide: Name of Company: _____ Policy #: _____
INJURED PERSON: <input type="checkbox"/> Athlete <input type="checkbox"/> Official <input type="checkbox"/> Coach <input type="checkbox"/> Spectator <input type="checkbox"/> Employee <input type="checkbox"/> Volunteer <input type="checkbox"/> Other _____ _____	DID THIS TAKE PLACE DURING: <input type="checkbox"/> Practice <input type="checkbox"/> Pre-Game <input type="checkbox"/> During Game <input type="checkbox"/> Post-Game <input type="checkbox"/> While Traveling <input type="checkbox"/> Other _____

INJURED PERSON INFORMATION			
Last Name	First	Middle	Telephone Number () <input type="checkbox"/> Single <input type="checkbox"/> Married
Address			Social Security Number: _____
City	State	Zip	Employer Name: _____
Age	D.O.B.	<input type="checkbox"/> Male <input type="checkbox"/> Female	Address: _____

GUARDIAN/PARENT (IF INJURED PERSON IS A MINOR)			
Last Name	First	Middle	Telephone Number ()
Address			City
			State
			Zip

INCIDENT LOCATION	INCIDENT	PRIMARY INJURY
<input type="checkbox"/> Competition area <input type="checkbox"/> Parking lot <input type="checkbox"/> Restrooms <input type="checkbox"/> Locker rooms <input type="checkbox"/> Premises/grounds <input type="checkbox"/> Bleachers/stands	<input type="checkbox"/> Concession area <input type="checkbox"/> Admission area <input type="checkbox"/> Off property <input type="checkbox"/> Store area <input type="checkbox"/> Assault/Sexual <input type="checkbox"/> Assault/Non-Sexual <input type="checkbox"/> Fall (different level) <input type="checkbox"/> Caught in/on/between <input type="checkbox"/> Collision (with object) <input type="checkbox"/> Struck by falling/flying object <input type="checkbox"/> Collision (participant/participant) <input type="checkbox"/> Collision (participant/spectator) <input type="checkbox"/> Collision (spectator/spectator)	<input type="checkbox"/> Slip/bodily reaction <input type="checkbox"/> Slip/Fall <input type="checkbox"/> Aquatic <input type="checkbox"/> Overexertion <input type="checkbox"/> Animal/insect bite/sting <input type="checkbox"/> Allergy <input type="checkbox"/> Amputation <input type="checkbox"/> Abrasion <input type="checkbox"/> Laceration <input type="checkbox"/> Drowning <input type="checkbox"/> Sting/bite <input type="checkbox"/> Cold Injury <input type="checkbox"/> Hypertension <input type="checkbox"/> Strain/Sprain <input type="checkbox"/> Dislocation <input type="checkbox"/> Cardiac <input type="checkbox"/> Foreign Body <input type="checkbox"/> Fracture <input type="checkbox"/> Cardiac <input type="checkbox"/> Contusion <input type="checkbox"/> Concussion <input type="checkbox"/> Tooth/Mouth <input type="checkbox"/> Electric Shock <input type="checkbox"/> Nausea <input type="checkbox"/> Stroke <input type="checkbox"/> Burn <input type="checkbox"/> Death <input type="checkbox"/> Pain <input type="checkbox"/> Illness <input type="checkbox"/> Seizures

BODY PART INJURED	DISPOSITION	CLASSIFICATION
<input type="checkbox"/> Eye - L or R <input type="checkbox"/> Nose <input type="checkbox"/> Neck <input type="checkbox"/> Ear - L or R <input type="checkbox"/> Knee - L or R <input type="checkbox"/> Internal <input type="checkbox"/> Shoulder - L or R <input type="checkbox"/> Elbow - L or R <input type="checkbox"/> Wrist - L or R <input type="checkbox"/> Torso <input type="checkbox"/> Back <input type="checkbox"/> Face <input type="checkbox"/> Leg - L or R <input type="checkbox"/> Ankle - L or R <input type="checkbox"/> Hip - L or R <input type="checkbox"/> Foot - L or R <input type="checkbox"/> Hand - L or R <input type="checkbox"/> Finger or Toe <input type="checkbox"/> Arm - L or R <input type="checkbox"/> Tooth <input type="checkbox"/> Head	<input type="checkbox"/> Released to parent <input type="checkbox"/> Refusal of care <input type="checkbox"/> Refer to doctor <input type="checkbox"/> Refer to hospital or clinic <input type="checkbox"/> Medical attention <input type="checkbox"/> EMS transport <input type="checkbox"/> Patient requested EMS transport <input type="checkbox"/> Released to personal vehicle <input type="checkbox"/> Police <input type="checkbox"/> Ambulance <input type="checkbox"/> Report only	<input type="checkbox"/> Non-Injury <input type="checkbox"/> Minor injury or illness <input type="checkbox"/> Serious injury or illness

DESCRIBE HOW THE INCIDENT OCCURRED: (attach a separate sheet if necessary)

WITNESS INFORMATION		
NAME	ADDRESS	TELEPHONE NUMBER
1.		()
2.		()

SIGNATURE OF PERSON COMPLETING FORM: _____ **DATE** _____

PRINTED NAME: _____ **PHONE:** _____