Accident/Injury Report Form

This form should be turned into the Assistant Director for Sport Programs within **24 hours** of accident/injury.

<table>
<thead>
<tr>
<th>Name:</th>
<th>Phone #:</th>
<th>Age:</th>
<th>Gender:</th>
<th>Status:</th>
<th>Student ID #:</th>
<th>Address:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date of Accident:</th>
<th>Time of Accident:</th>
<th>Description of activity participating in when accident or illness occurred:</th>
<th>Exact location where accident or illness occurred:</th>
</tr>
</thead>
</table>

<table>
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<tr>
<th>Events leading up to accident or illness:</th>
<th>What specific things are speculated to have caused the event to occur? (other participants’ actions, improper use of equipment, etc.):</th>
</tr>
</thead>
</table>

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<tr>
<th>Photographs of Accident Site:</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

Please check the appropriate blank.

**Body Part Injured** (please circle left or right and specific area of injury, if more than one body part effected check and circle all that apply):
- [ ] not applicable (Medical Illness, etc.)
- [ ] face/nose
- [ ] neck/shoulder/back
- [ ] chest/abdomen/stomach/hip
- [ ] head
- [ ] toe
- [ ] finger
- [ ] arm/elbow (left or right)
- [ ] hand (left or right)
- [ ] eye (left or right)
- [ ] foot/ankle (left or right)
- [ ] other

**Treatment given** (please check all that apply):
- [ ] cleaned
- [ ] bandaged
- [ ] gave CPR
- [ ] applied compress
- [ ] treated for shock
- [ ] gave CPR
- [ ] applied ice
- [ ] control breathing
- [ ] rescue breathing
- [ ] called EMS
- [ ] other
Disposition
__ remained in area __ advised to see Health Services
__ advised to see a Doctor __ other ________________
__ transported or treated by Emergency personnel (also complete following section)

Advance Care Information:
Patient Refused Care or Transport	YES	NO

Responding Units who assisted with Transporting Patient:
Contact Name, Phone Number, Address:________________________________________________________
Contact Name, Phone Number, Address:________________________________________________________

Location the person was transported to:
Was person transported to a medical facility:	YES	NO
How where they transported to the facility:______________________________________________________
Name of facility patient was transported to:_______________________________________________________
Was patient admitted to the facility:	YES	NO
Name and Phone Number of Admitting Person:_____________________________________________________
Room or Area Patient was admitted to:___________________________________________________________

Injured Person’s Signature		Date
Witnesses
<table>
<thead>
<tr>
<th>Name:</th>
<th>Date:</th>
<th>Signature:</th>
</tr>
</thead>
<tbody>
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</tr>
</tbody>
</table>

Person completing form (please print) Phone Number Date Report Completed

Signature of person completing form ____________________________________________________________

Office use only

Professional Staff Member’s Signature	Date Reviewed

Action Steps Taken: Date Implemented
1) ____________________________________________
2) ____________________________________________
3) ____________________________________________
4) ____________________________________________