

Facility/Location accident occurred: \_\_\_\_\_

Date: \_\_\_\_\_ Time \_\_\_\_\_ AM / PM

Name of injured: \_\_\_\_\_ Sex: M / F \_\_\_\_\_ Age \_\_\_\_\_

Address: \_\_\_\_\_ Phone \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Alt. Phone \_\_\_\_\_



**TYPE OF INJURY**

- \_\_\_\_\_ abrasion
  - \_\_\_\_\_ bleeding
  - \_\_\_\_\_ bruise
  - \_\_\_\_\_ concussion
  - \_\_\_\_\_ heat/cold related illness
  - \_\_\_\_\_ distressed swimmer
  - \_\_\_\_\_ no apparent injury, but complained of pain.
  - \_\_\_\_\_ other (specify) \_\_\_\_\_
- \_\_\_\_\_ faint
  - \_\_\_\_\_ cramp
  - \_\_\_\_\_ fracture
  - \_\_\_\_\_ choking
  - \_\_\_\_\_ dislocation
  - \_\_\_\_\_ laceration

**PART OF BODY INJURED**

FRONT

BACK



BRIEF DESCRIPTION OF INJURY: (use back side if needed):

LOCATION WHERE INJURY OCCURRED (BE SPECIFIC):

WHAT PIECE OF EQUIPMENT, IF ANY, WAS INVOLVED IN THE ACCIDENT/RESCUE?

SEE REVERSE

ACTIVITY ENGAGED IN AT TIME OF THE ACCIDENT:

CAUSE OF ACCIDENT:

**TYPE OF AID ADMINISTERED:**

- \_\_\_\_\_ bandage
  - \_\_\_\_\_ compress
  - \_\_\_\_\_ splint
  - \_\_\_\_\_ ice pack
  - \_\_\_\_\_ other (specify) \_\_\_\_\_
- \_\_\_\_\_ Artificial R.
  - \_\_\_\_\_ Heimlich M.
  - \_\_\_\_\_ spinal board
  - \_\_\_\_\_ treat for shock
  - \_\_\_\_\_ rescue

WAS A RULE BROKEN? Y / N If yes, then explain infraction

WAS THERE SUPERVISION OF INJURED PERSON? Y / N

Name & Relation & Age: \_\_\_\_\_

WERE PARENTS NOTIFIED? Y / N \_\_\_\_\_ If yes, date/time: \_\_\_\_\_

WAS 911 CALLED? Y / N \_\_\_\_\_

WERE THE POLICE NOTIFIED? Y / N \_\_\_\_\_

**STATUS OF INJURED PERSON:**

- \_\_\_\_\_ released to care of parent/guardian
- \_\_\_\_\_ went back to activity
- \_\_\_\_\_ advised to go home
- \_\_\_\_\_ advised to seek future treatment
- \_\_\_\_\_ other: \_\_\_\_\_

Comment (include #'s called):

NOTES:

\*Witness Names on side 2 of form.



**Aid Administered By:**

**Report Written By:**

**Reviewed By:**

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Position: \_\_\_\_\_

Position: \_\_\_\_\_

Position: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

Page 2

WITNESS NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY/STATE/ZIP: \_\_\_\_\_  
PHONE: \_\_\_\_\_

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ADDRESS: \_\_\_\_\_  
CITY/STATE/ZIP: \_\_\_\_\_  
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WITNESS NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY/STATE/ZIP: \_\_\_\_\_  
PHONE: \_\_\_\_\_

Brief Description of Injury:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**S**igns & symptoms of injury/illness \_\_\_\_\_

**A**re you allergic to anything? \_\_\_\_\_

**M**edications you are taking? \_\_\_\_\_

**P**ast illnesses or medical conditions? \_\_\_\_\_

**L**ast food, drink or medication taken? \_\_\_\_\_

**E**xplain the events leading up to injury or illness. \_\_\_\_\_

Additional Comments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_