



## Incident Report

**IMPORTANT: Complete both sides of this report (Page 1 of 2)**

Injured Person: <input type="checkbox"/> Official <input type="checkbox"/> Athlete <input type="checkbox"/> Coach <input type="checkbox"/> Spectator <input type="checkbox"/> Volunteer <input type="checkbox"/> Other:					
Name:		First	Middle	Last	
		<input type="checkbox"/> Male	<input type="checkbox"/> Female	Date of Birth:	
Phone:			Email:		
Address: _____ _____					
<i>Parent / Guardian (If injured person is a minor - Under 16)</i>					
Name:		First	Middle	Last	<input type="checkbox"/> Male <input type="checkbox"/> Female
Phone:			Email:		
Address: _____ _____					

Name of Event:	
Event Location: _____ _____	

### Incident Information

Classification: <input type="checkbox"/> Non-Injury <input type="checkbox"/> Minor Injury <input type="checkbox"/> Serious Injury					
Date:			Time: _____ am / pm		
Location:					
Type: <input type="checkbox"/> Collision between: <input type="checkbox"/> Struck by falling/flying object <input type="checkbox"/> Animal/Insect bite/sting <input type="checkbox"/> Slip/Fall <input type="checkbox"/> Other					
Body Part: <input type="checkbox"/> Head <input type="checkbox"/> Eye                      L / R <input type="checkbox"/> Ear                      L / R <input type="checkbox"/> Nose <input type="checkbox"/> Tooth <input type="checkbox"/> Neck <input type="checkbox"/> Shoulder                      L / R <input type="checkbox"/> Wrist                      L / R <input type="checkbox"/> Finger                      L / R <input type="checkbox"/> Back <input type="checkbox"/> Knee                      L / R <input type="checkbox"/> Ankle                      L / R <input type="checkbox"/> Internal <input type="checkbox"/> No Injury <input type="checkbox"/> Other:					
Primary Injury: <input type="checkbox"/> Allergy <input type="checkbox"/> Amputation <input type="checkbox"/> Foreign Body <input type="checkbox"/> Laceration <input type="checkbox"/> Heat Exhaustion <input type="checkbox"/> Hypertension <input type="checkbox"/> Cold Injury <input type="checkbox"/> Electrical Shock <input type="checkbox"/> Strain / Sprain <input type="checkbox"/> Abrasion <input type="checkbox"/> Illness <input type="checkbox"/> Dislocation <input type="checkbox"/> Nausea <input type="checkbox"/> Burn <input type="checkbox"/> Fracture <input type="checkbox"/> Pain <input type="checkbox"/> Cardiac <input type="checkbox"/> Contusion <input type="checkbox"/> Seizures <input type="checkbox"/> Concussion <input type="checkbox"/> Sting / Bite <input type="checkbox"/> Death <input type="checkbox"/> Other:					

