

ATHLETIC INJURY REPORT FORM

1. School Name: _____ 2. Activity: _____ 3. Date of Injury: _____

4. Student's Name: _____ 5. Grade: _____ 6. Time of Injury: _____

7. Address: _____ Telephone: _____ () Male () Female

8. Location of Accident: () Classroom () Field () Gym () Locker Room () Game () Practice () Other

9. Body Part Injured: **HEAD** **TRUNK** **EXTREMITIES** **OTHER**

<input type="checkbox"/> Ear	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Ankle	<input type="checkbox"/> Lower Arm	_____
<input type="checkbox"/> Eye	<input type="checkbox"/> Back	<input type="checkbox"/> Elbow	<input type="checkbox"/> Lower Leg	_____
<input type="checkbox"/> Face	<input type="checkbox"/> Chest	<input type="checkbox"/> Finger	<input type="checkbox"/> Thumb	_____
<input type="checkbox"/> Head	<input type="checkbox"/> Chest	<input type="checkbox"/> Foot	<input type="checkbox"/> Toes	_____
<input type="checkbox"/> Neck	<input type="checkbox"/> Groin	<input type="checkbox"/> Hand	<input type="checkbox"/> Upper Arm	_____
<input type="checkbox"/> Scalp	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Hip	<input type="checkbox"/> Upper Leg	_____
		<input type="checkbox"/> Knee	<input type="checkbox"/> Wrist	_____

10. Type of Injury: Abrasion Bite Bruise **OTHER**

<input type="checkbox"/> Burn	<input type="checkbox"/> Concussion	<input type="checkbox"/> Cut	_____
<input type="checkbox"/> Dislocation	<input type="checkbox"/> Fracture	<input type="checkbox"/> Heat	_____
<input type="checkbox"/> Laceration	<input type="checkbox"/> Puncture	<input type="checkbox"/> Scratch	_____
<input type="checkbox"/> Shock	<input type="checkbox"/> Sprain	<input type="checkbox"/> Strain	_____

11. First Aid Given: Applied Dressing Applied Splint Ice **OTHER**

<input type="checkbox"/> Kept Immobile	<input type="checkbox"/> Stopped bleeding	<input type="checkbox"/> Observed	_____
<input type="checkbox"/> Washed Wound			_____

12. Action Taken: Parent took home Transfer to hospital Parent took to doctor

<input type="checkbox"/> Returned to sport	<input type="checkbox"/> Parent took to ER	<input type="checkbox"/> Called 911
<input type="checkbox"/> Other: _____		

13. Explanation of Accident:

<input type="checkbox"/> Collision with person	<input type="checkbox"/> Collision with obstacle	<input type="checkbox"/> Fall
<input type="checkbox"/> Hit with object	<input type="checkbox"/> Injury to self	
<input type="checkbox"/> Other: _____		

14. Describe: Describe specifically how the injury happened. _____

15. Witness 1: _____ Witness 2: _____

Address: _____	Address: _____
Phone #: _____	Phone #: _____

16. Form Submitted by: _____

Signature/Date: _____

Address: _____

Telephone #: _____

Please attach additional comments / information on back of sheet