SPORTS INJURY REPORT FORM

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This form is to be completed by a Coach or Club Official at the time of injury

SUBMIT THIS FORM TO:
A Club Official at the Clubhouse Within 2 DAYS of the injury occurrence.

First Name: _____ **Last Name:** _____ **Date of Injury:** _____

Address: _____ **City:** _____ **Prov:** _____ **Phone No:** (____)_____

E-mail Address: _____ **Cell No:** (____) _____ **Time of Injury:** _____ A.M./P.M. (circle)

Referee:_____**Parent/Guardian:**_____(If applicable) **Time of Game**: ____Min._____ Half (1st/2nd)

SECTION A: PERSON INJURED ☐ Player ☐ Official ☐ Coach ☐ Other

(1st) Witness: _____ (Full Name) Position:_____ Contact No: (___)_____

(2nd) Witness: _____ (Full Name) Position:_____Contact No: (___)_____

Location of Injury: ☐ Outdoor Field ☐ Hershey SportsZone ☐ Clubhouse ☐ Stands/ Dressing Room ☐ Other

Field/ Facility: _____ **Team Name**: _____ **League Name/Event:**_____

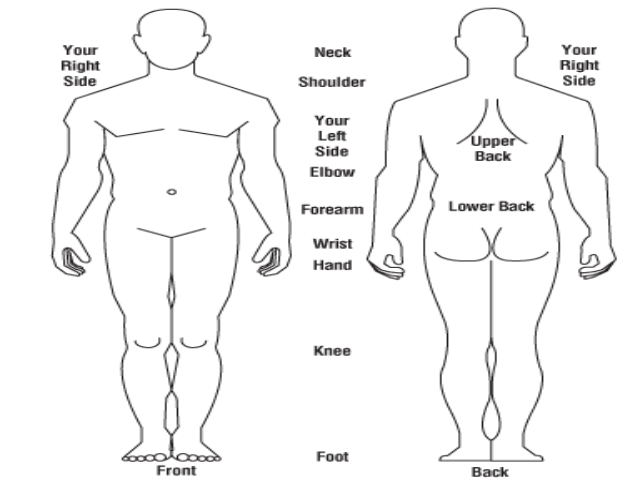
Completed By:_____ **Position**:_____ Phone No: (____)_____

Type of Activity: ☐ League Game ☐ H. L. Game ☐ Team Practice ☐ Tournament ☐ Central H.L. Training ☐ ADP ☐ Other

Injury Occurred During: ☐ Pre-Season ☐ Outdoor Season ☐ Playoffs ☐ Indoor Season ☐ Post-Season

PLEASE COMPLETE SECTION "A" ABOVE IN FULL AND AS MUCH OF SECTION "B" BELOW AS POSSIBLE

SECTION B: DETAILS OF INJURY (INDICATE &ATTACH ADDITIONAL SCHEDULES, IF NECESSARY)



Please circle and indicate the injured body part on the diagram above.
State below what caused the injury and if it could have been avoided:

Please indicate in the diagram where the injury occurred:

Injured Party: ☐ Male ☐ Female **Date of Birth**: _____ (Day/ Mth./ Yr.)

Weight (lbs): _____ **Height** (ft./in.): _____

Anticipated Injury Time Loss: ☐ 0 Days ☐ 1-5 Days ☐ 5-10 Days ☐ 10+

Nature of Injury:
☐ Fracture ☐ Laceration ☐ Sprain/ Strain ☐ Head Injury
☐ Dislocation ☐ Skin Injury ☐ Recurring Injury
☐ Other (Specify) _____
_____

Injury Type: ☐ Contact ☐ Non-Contact
Symptoms: ☐Loss of Feeling ☐ Pain ☐ Dizziness
☐ Shortness of Breath ☐ Loss of Consciousness/ Fainting*
☐ Other (Specify) _____
_____

***All loss of consciousness or fainting requires IMMEDIATE medical follow-up - CALL**

First Aid/Care: ☐ Trainer ☐ Hospital ☐ EMS ☐ Family Dr. ☐ Coach ☐ Other
If treated at Hospital, party transported by: ☐ Ambulance ☐ Private Vehicle
Driver: _____ **Caregiver**: _____ (if known)
Initial Treatment: ☐ Rice (Rest, Immobilize, Cold, Elevate)
☐ CPR ☐ Stretching ☐ Manual Therapy ☐ Dressing
☐ Wrapping/ Taping ☐ Sling/ Splint ☐ None

Was Injured Party wearing any protective equipment or other devices, shin guards, glasses, other personal equipment? ☐Yes ☐No Please describe: _____
Has injured party filed an insurance claim ☐ Yes ☐ No
Name of Insurance Company: _____

SIGNATURE OF INJURED PARTY (PARENT OR LEGAL GUARDIAN):
_____

SIGNATURE & NAME OF WITNESS:
_____ _____

Date: _____ (Day/ Month/ Year)

ALL INFORMATION COLLECTED ON THIS FORM IS OF A PERSONAL NATURE AND IS STRICTLY CONFIDENTIAL AND WILL NOT BE DISCLOSED TO ANY THIRD PARTY EXCEPT AS REQUIRED FOR INSURANCE PURPOSES OR AS AUTHORIZED BY THE INJURED PARTY OR THEIR PARENTS/ LEGAL GUARDIANS OR AS MAY BE REQUIRED BY LAW