



2008/2009 MSC INCIDENT REPORT FORM

Use in the event of Injury, Incident or Property Damage

INJURED PERSON INFORMATION/PROPERTY DAMAGE OWNER:

Last Name _____ First Name _____ MI _____ Telephone: _____

Address: _____ Player Pass # _____

City: _____ State: _____ Zip: _____ Age: _____ D.O.B.: _____

Team Name: _____ Division: _____ Gender: Male Female

Does the injured person have other medical insurance? Yes No *If yes, please provide name of company and policy #:* _____

INJURED PERSON: Player Official Coach Spectator Volunteer Other: _____

GUARDIAN/PARENT (if injured person is a minor):

Last Name _____ First Name _____ MI _____ Telephone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

INCIDENT INFORMATION: Date of Incident: _____ Time of Incident: _____ AM / PM

<p>BODY PART INJURED</p> <p><input type="checkbox"/> Nose <input type="checkbox"/> Head <input type="checkbox"/> Tooth <input type="checkbox"/> Ankle (L/R) <input type="checkbox"/> Knee (L/R) <input type="checkbox"/> Shoulder (L/R) <input type="checkbox"/> Wrist (L/R) <input type="checkbox"/> Finger <input type="checkbox"/> Eye (L/R) <input type="checkbox"/> Ear (L/R) <input type="checkbox"/> Back <input type="checkbox"/> Neck <input type="checkbox"/> Internal <input type="checkbox"/> No injury <input type="checkbox"/> Other</p>	<p>PRIMARY INJURY</p> <p><input type="checkbox"/> Abrasion <input type="checkbox"/> Burn <input type="checkbox"/> Cardiac <input type="checkbox"/> Cold Injury <input type="checkbox"/> Concussion <input type="checkbox"/> Contusion <input type="checkbox"/> Dislocation <input type="checkbox"/> Foreign Body <input type="checkbox"/> Fracture <input type="checkbox"/> Heat Exhaustion <input type="checkbox"/> Nausea <input type="checkbox"/> Laceration <input type="checkbox"/> Pain <input type="checkbox"/> Seizures <input type="checkbox"/> Sting/Bite <input type="checkbox"/> Strain/Sprain</p>	<p>If ankle injury, was ankle:</p> <p><input type="checkbox"/> Taped/Supported <input type="checkbox"/> Unsupported Shoes: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <hr/> <p>If knee injury, was knee:</p> <p><input type="checkbox"/> Braced/Supported <input type="checkbox"/> Unsupported Knee Pads: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <hr/> <p>FIELD SURFACE</p> <p><input type="checkbox"/> Dirt <input type="checkbox"/> Grass <input type="checkbox"/> Indoor</p> <hr/> <p>CLASSIFICATION</p> <p><input type="checkbox"/> Non-Injury <input type="checkbox"/> Minor Injury or Illness <input type="checkbox"/> Serious Injury or Illness</p>	<p style="text-align: center;"><u>INCIDENT</u></p> <p><input type="checkbox"/> Collision (participant/spectator) <input type="checkbox"/> Collision (with object) <input type="checkbox"/> Collision (participant/participant) <input type="checkbox"/> Collision (spectator/spectator) <input type="checkbox"/> Struck by falling /flying object <input type="checkbox"/> Caught in, on, between goal <input type="checkbox"/> Animal/insect bite/sting <input type="checkbox"/> Slip/Fall <input type="checkbox"/> Overexertion <input type="checkbox"/> Assault/Sexual <input type="checkbox"/> Assault/Non-Sexual <input type="checkbox"/> Property Damage</p>
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<p><u>LOCATION</u></p> <p><input type="checkbox"/> Before Competition/Event <input type="checkbox"/> During Competition/Event <input type="checkbox"/> After Competition/Event <input type="checkbox"/> Competition Area <input type="checkbox"/> Concession Area <input type="checkbox"/> Parking Lot <input type="checkbox"/> Restrooms <input type="checkbox"/> Off Property</p>	<p><u>DISPOSITION</u></p> <p>No care given: <input type="checkbox"/> Not Needed <input type="checkbox"/> Patient Refused</p> <p>Released: <input type="checkbox"/> To Parent <input type="checkbox"/> To Personal Vehicle <input type="checkbox"/> To Doctor <input type="checkbox"/> To Hospital/Clinic</p> <p>EMS transport: <input type="checkbox"/> Coach Recommended <input type="checkbox"/> Patient/Parent Requested</p>	<p>POLICE REPORT FILED: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, report number: _____</p> <p>Officer's Name: _____</p> <p>City, State: _____</p> <p>Extra info: _____</p>
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Describe how the incident, injury or property damage occurred: (use the backside or attach a separate sheet if necessary)

WITNESS Name(s)	Address	Telephone Number
_____	_____	_____
_____	_____	_____

Person completing this form:

Name: _____ Signature: _____ Date: _____ Phone: _____

This report is to be signed and submitted to the Coach or Safety Administrator within 48 hours of incident