

DISABLED SPORTS USA INCIDENT REPORT FORM



Please submit a signed waiver for injured person, along with this form, within 48 hours of incident
Two page form must be completed by official chapter representative – please print legibly

Date of Incident:		Time of Incident:	
Chapter Name:		State:	
Executive Director:		Exec. Dir. Email:	
INJURED PERSON INFORMATION			
First Name:	Middle Initial:	Last Name:	
Phone Number:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	
Address:	City:	State:	Zip:
Disability:			<input type="checkbox"/> N/A
Injured Person: <input type="checkbox"/> Participant <input type="checkbox"/> Employee <input type="checkbox"/> Volunteer <input type="checkbox"/> Other: _____			
PARENT/LEGAL GUARDIAN (IF INJURED PERSON IS A MINOR OR LEGALLY INCAPACITATED)			
First Name:	Last Name:	Phone Number:	
Address:	City:	State:	Zip:
INJURY INFORMATION			
PRIMARY INJURY RESULTING FROM INCIDENT: <input type="checkbox"/> Abrasion <input type="checkbox"/> Hypertension <input type="checkbox"/> Allergy <input type="checkbox"/> Hypothermia <input type="checkbox"/> Amputation <input type="checkbox"/> Laceration <input type="checkbox"/> Burn <input type="checkbox"/> Illness <input type="checkbox"/> Cardiac <input type="checkbox"/> Nausea <input type="checkbox"/> Cold Injury <input type="checkbox"/> Pain <input type="checkbox"/> Concussion <input type="checkbox"/> Seizures <input type="checkbox"/> Contusion <input type="checkbox"/> Sting/Bite <input type="checkbox"/> Dislocation <input type="checkbox"/> Strain/Sprain <input type="checkbox"/> Foreign Body <input type="checkbox"/> Stroke <input type="checkbox"/> Fracture <input type="checkbox"/> Tooth/Mouth <input type="checkbox"/> Heat Exhaustion <input type="checkbox"/> Other: _____		BODY PART INJURED: <input type="checkbox"/> Ankle (L / R) <input type="checkbox"/> Internal <input type="checkbox"/> Arm (L / R) <input type="checkbox"/> Knee (L / R) <input type="checkbox"/> Back <input type="checkbox"/> Leg (L / R) <input type="checkbox"/> Ear (L / R) <input type="checkbox"/> Neck <input type="checkbox"/> Elbow (L / R) <input type="checkbox"/> Nose <input type="checkbox"/> Eye (L / R) <input type="checkbox"/> Shoulder (L / R) <input type="checkbox"/> Face <input type="checkbox"/> Toe <input type="checkbox"/> Finger <input type="checkbox"/> Tooth <input type="checkbox"/> Foot (L / R) <input type="checkbox"/> Torso <input type="checkbox"/> Hand (L / R) <input type="checkbox"/> Wrist (L / R) <input type="checkbox"/> Head <input type="checkbox"/> Other: _____ <input type="checkbox"/> Hip	
INCIDENT INFORMATION			
PRIMARY CAUSE OF INCIDENT: <input type="checkbox"/> Animal bite/sting <input type="checkbox"/> Assault/non-sexual <input type="checkbox"/> Collision with person <input type="checkbox"/> Struck by falling /flying object <input type="checkbox"/> Aquatic <input type="checkbox"/> Caught in, on, between <input type="checkbox"/> Fall/Slip <input type="checkbox"/> Other: _____ <input type="checkbox"/> Assault/sexual <input type="checkbox"/> Collision with object <input type="checkbox"/> Fall from height			
INCIDENT LOCATION: <input type="checkbox"/> Activity Site <input type="checkbox"/> Administrative Premises/Grounds <input type="checkbox"/> Off Property <input type="checkbox"/> Other: _____			
INCIDENT TOOK PLACE DURING: <input type="checkbox"/> Lesson <input type="checkbox"/> Competition <input type="checkbox"/> Training <input type="checkbox"/> Guiding <input type="checkbox"/> Other: _____			
WEATHER CONDITIONS: <input type="checkbox"/> Clear <input type="checkbox"/> Icy <input type="checkbox"/> Fog <input type="checkbox"/> Rain <input type="checkbox"/> Snow <input type="checkbox"/> N/A <input type="checkbox"/> Other: _____			
INCIDENT TOOK PLACE DURING WHAT SPORT/ACTIVITY:			
EQUIPMENT INVOLVED IN INCIDENT:			

PLEASE COMPLETE 2ND PAGE

The completed incident report is an internal document and may only be shared with Disabled Sports USA National Headquarters.

Revised 5/2016

1/2

Report and waiver must be submitted within 48 hours of incident to:

Attn: Cheryl Collins: CCollins@dsusa.org or Fax 301-217-0968. Questions? 301-217-9841

DISABLED SPORTS USA INCIDENT REPORT FORM



DESCRIPTION OF INCIDENT

Please be as descriptive as possible and include all relevant information, including: Who was involved (please provide names and roles)? Where were they? What happened? What was the sequence of events? *Attach a separate sheet if necessary.*

RESPONSE TO INCIDENT

Please list any first aid or medical treatment provided at the time of incident? ☐ Refused Treatment

WHAT AID OR TREATMENT WAS PROVIDED?	WHO PROVIDED THE TREATMENT?	WHERE WAS AID OR TREATMENT PROVIDED?

PLEASE CHECK ALL THAT APPLY:

- | | | |
|---|---|--|
| <input type="checkbox"/> Transported by ambulance to hospital | <input type="checkbox"/> Referred to doctor | <input type="checkbox"/> Ski patrol assisted |
| <input type="checkbox"/> Transported by air ambulance to hospital | <input type="checkbox"/> Referred to hospital or clinic | <input type="checkbox"/> Police involved |
| <input type="checkbox"/> Transported by ambulance to hospital at the request of patient/parent/guardian | <input type="checkbox"/> Released to parent/guardian | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Self-transported to hospital or clinic | <input type="checkbox"/> Released to self | _____ |

If individual is a minor or legally incapacitated, was the parent/legal guardian notified? ☐ Yes ☐ No *If yes, when?*

Any additional information?

WITNESS INFORMATION

NAME	ROLE	ADDRESS	ZIP CODE	PHONE NUMBER

REPORTER'S INFORMATION

Name:	Position:	Date:
Address:		Phone Number:

The completed incident report is an internal document and may only be shared with Disabled Sports USA National Headquarters.