Special Olympics
British Columbia
Kamloops

MEDICAL INCIDENT REPORT FORM

Name(s) of Person(s) Involved: _____

Date of Accident: _____

Location of Accident: _____

_____

Description of Accident: _____

_____

_____

_____

Description of Injury: _____

_____

_____

Action(s) Taken: _____

_____

_____

Follow Up Action(s) Required: _____

_____

_____

Date: _____ Signature: _____

Name & Position: _____