Injury Report Form

(all shaded areas must be completed)

Date_____ Time_____ am / pm Day: MON TUE WED THU FRI SAT SUN

Name_____ Phone ( )_____

Address_____

City_____ State_____ Zip_____

Date of Birth_____ Age_____ Sex: M F

Location of Incident_____

Location of Injury

	( )Head	( )Face	( )Eye	( )Nose	( )Knee
Left____	( )Mouth	( )Neck	( )Chin	( )Collar Bone	( )Ankle
	( )Shoulder	( )Arm	( )Elbow	( )Wrist	( )Foot
Right___	( )Hand	( )Finger	( )Chest	( )Back	( )Toe
	( )Abdomen	( )Hips/Waist	( )Buttocks	( )Legs	( )Other _____

Nature of Injury

( )Abrasion	( )Puncture	( )Laceration	( )Contusion
( )Avulsion	( )Fracture	( )Sprain	( )Strain
( )Dislocation	( )Burn	( )Respiratory	( )Cold related
( )Heat related	( )Allergy related	( )Previous/Existing	( )Other_____

Mechanism of Injury

( )Contact with other	( )Contact with object
( )Slip/Trip/Fall	( )Other _____

Details of Injury _____

Events Leading up to Injury _____

Treatment and Response _____

Parents notified: Yes_____ No_____ (if not, who was notified)_____

Witness Name_____ Phone_____

Staff signature_____ Date_____

Supervisor signature_____ Date_____