

# Accident/Incident Report

---

Program Location: \_\_\_\_\_

# Staff: \_\_\_\_\_ # Participants: \_\_\_\_\_ # Volunteers: \_\_\_\_\_

Name: \_\_\_\_\_ (circle) staff / participant Age: \_\_\_\_\_

Incident Date: \_\_\_\_\_ Time: \_\_\_\_\_ am/pm

Geographic Location of Incident: \_\_\_\_\_

---

## **WEATHER at time of incident:**

Temp (F): \_\_\_\_\_ Precipitation (circle all that apply): Rain Snow None

Surface condition (circle all that apply): wet dry snow ice rock uneven flat sloped

---

## **TYPE OF INCIDENT: (Check each applicable category)**

Injury \_\_\_\_\_ Illness \_\_\_\_\_ Motivation/Behavior \_\_\_\_\_

Did the victim leave the program site? \_\_\_\_\_NO \_\_\_\_\_YES

Evacuation method (circle): walked unassisted carried vehicle ambulance helicopter

Did the victim visit a medical facility? \_\_\_\_\_NO \_\_\_\_\_YES

If Yes, length of stay \_\_\_\_\_day(s)

Did the victim return to the program? \_\_\_\_\_NO \_\_\_\_\_YES

If Yes, on what date: \_\_\_\_\_

Did the victim visit a medical facility later? \_\_\_\_\_NO \_\_\_\_\_YES

If Yes, on what date: \_\_\_\_\_

Was there damage to (circle): equipment property vehicle?

---

**TYPE OF INJURY: (Check all that apply)**

- |   |  |
|---|--|
| <input type="checkbox"/> bruise, contusion, or similar soft-tissue trauma | <input type="checkbox"/> ligament sprain         |
| <input type="checkbox"/> muscle strain                                    | <input type="checkbox"/> tendinitis              |
| <input type="checkbox"/> frostbite  | <input type="checkbox"/> eye injury              |
| <input type="checkbox"/> fracture   | <input type="checkbox"/> dental or tooth-related |
| <input type="checkbox"/> dislocation                                      | <input type="checkbox"/> blister(s)              |
| <input type="checkbox"/> head injury with loss of consciousness           | <input type="checkbox"/> laceration              |
| <input type="checkbox"/> head injury without loss of consciousness        | <input type="checkbox"/> skin abrasions          |
| <input type="checkbox"/> sunburn  |  |
| <input type="checkbox"/> other _____                                      |  |

Describe extent of injury:

---

**ANATOMICAL LOCATION OF INJURY:**

- |                                    |                                       |                                    |
|------------------------------------|---------------------------------------|------------------------------------|
| <input type="checkbox"/> Head      | <input type="checkbox"/> Forearm      | <input type="checkbox"/> Pelvis    |
| <input type="checkbox"/> Face      | <input type="checkbox"/> Wrist        | <input type="checkbox"/> Hip       |
| <input type="checkbox"/> Eye       | <input type="checkbox"/> Hand/Fingers | <input type="checkbox"/> Thigh     |
| <input type="checkbox"/> Neck      | <input type="checkbox"/> Chest        | <input type="checkbox"/> Knee      |
| <input type="checkbox"/> Shoulder  | <input type="checkbox"/> Abdomen      | <input type="checkbox"/> Lower Leg |
| <input type="checkbox"/> Upper Arm | <input type="checkbox"/> Upper Back   | <input type="checkbox"/> Foot/Toe  |
| <input type="checkbox"/> Elbow     | <input type="checkbox"/> Lower Back   | <input type="checkbox"/> Ankle     |

Describe further if necessary (left/right, specific location):

---

**TYPE OF ILLNESS: (Check all that apply)**

- allergic reaction
  - mild or localized
  - severe, generalized or anaphylaxis
- hypothermia (specify core temperature if known \_\_\_F/\_\_\_C)
- heat illness (specify core temperature if known \_\_\_F/\_\_\_C)
  - heat exhaustion
  - heat cramps
  - heat stroke
- chest pain or cardiac condition
- upper respiratory illness (runny nose, congestion, "cold")
- upper respiratory illness (other: \_\_\_\_\_)
- asthma
- abdominal or other gastrointestinal problem without diarrhea
- diarrhea

- apparent food-related illness
  - nonspecific fever illness
  - skin infection
  - eye infection
  - other \_\_\_\_\_
- 

**POSSIBLE CONTRIBUTING CAUSES: (Circle all that apply, prioritize major applicable categories 1, 2, 3, etc.)**

- |   |  |
|---|--|
| <input type="checkbox"/> Cold Exposure                  | <input type="checkbox"/> Preexisting medical condition         |
| <input type="checkbox"/> Carelessness by participant    | <input type="checkbox"/> Misbehavior                           |
| <input type="checkbox"/> Dark/poor visibility           | <input type="checkbox"/> Overuse injury                        |
| <input type="checkbox"/> Dehydration                    | <input type="checkbox"/> Hazardous animal/insect(specify)_____ |
| <input type="checkbox"/> Exceeded ability               | <input type="checkbox"/> Plant poisoning                       |
| <input type="checkbox"/> Exhaustion                     | <input type="checkbox"/> Psychological                         |
| <input type="checkbox"/> Fall/Slip                      | <input type="checkbox"/> Poor technique                        |
| <input type="checkbox"/> Failure to follow instructions | <input type="checkbox"/> Weather                               |
| <input type="checkbox"/> Falling tree/branch            | <input type="checkbox"/> Other (explain)_____                  |
| <input type="checkbox"/> Lightning                      |  |
- 

**OTHER QUESTIONS:**

- Has the injured party signed a release and is it available? \_\_\_\_\_
- Has the injured party participated in this activity at this location before? \_\_\_\_\_
- Does the injured party presently have any type of medical coverage?     NO     YES
- If "yes" please specify the name of the Company \_\_\_\_\_
- Did the injured party contribute to the accident in any way? \_\_\_\_\_
- Did the injured party accept or refuse first aid?                     NO     YES
- Did another participant contribute to the injury? (Describe) \_\_\_\_\_
- Were there warnings or instructions that were not heeded?     NO     YES
- If "yes" please describe \_\_\_\_\_
- Were there other people injured in this accident? (Describe) \_\_\_\_\_
-

**WITNESS(ES):**

Name\_\_\_\_\_

Address\_\_\_\_\_

City\_\_\_\_\_ State\_\_\_\_\_ Zip\_\_\_\_\_

Home Phone\_\_\_\_\_ Work Phone\_\_\_\_\_

Name\_\_\_\_\_

Address\_\_\_\_\_

City\_\_\_\_\_ State\_\_\_\_\_ Zip\_\_\_\_\_

Home Phone\_\_\_\_\_ Work Phone\_\_\_\_\_



**REPORT COMPLETED BY:**

Name  
\_\_\_\_\_

Address  
\_\_\_\_\_

E-mail  
\_\_\_\_\_

Phone  
\_\_\_\_\_