DISABLED SPORTS USA INCIDENT REPORT FORM

2 PAGE FORM MUST BE COMPLETED BY OFFICIAL CHAPTER REPRESENTATIVE – PLEASE PRINT LEGIBLY

Please submit copy of signed waiver for injured person along with form within 48 hours of incident

Date of Incident:	Time of Incident:		
Chapter Name:	Executive Director:		
Chapter Address:	City:	State:	Zip:
Exec. Dir. Email:	Exec. Dir. Phone:		

INJURED PERSON INFORMATION

First Name: Middle Name: Last Name:			
Phone Number:	Gender: ☐ Male ☐ Female		
Address:	City:	State:	Zip:
Age:	Date of Birth:		
Disability (Please be as specific as possible):			

INJURED PERSON:
☐ Participant ☐ Coach ☐ Employee ☐ Volunteer
☐ Other: _____

INCIDENT TOOK PLACE DURING:
☐ Event: _____
☐ Lesson ☐ Post-Event ☐ Training ☐ Guiding
☐ Other: _____

PARENT/LEGAL GUARDIAN (IF INJURED PERSON IS A MINOR)

First Name:	Last Name:	Phone Number:	
Address:	City:	State:	Zip:

DESCRIPTION OF INCIDENT

INCIDENT LOCATION
☐ Activity Site
☐ Administrative Premises/Grounds
☐ Off Property
☐ Other: _____

INJURY CLASSIFICATION:
☐ Non-Injury
☐ Minor Injury or Illness
☐ Major Injury or Illness

INCIDENT
☐ Animal bite/sting
☐ Aquatic
☐ Assault/sexual
☐ Assault/non-sexual
☐ Caught in, on, between
☐ Collision w/ object
☐ Collision w/ person
☐ Fall
☐ Slip/fall
☐ Struck by falling /flying object
☐ Other: _____

DISPOSITION
☐ Ambulance
☐ EMS transport
☐ Patient requested EMS transport
☐ Police
☐ Refer to doctor
☐ Refer to hospital or clinic
☐ Refusal of care
☐ Released to parent/guardian
☐ Report Only
☐ Self-transport to hospital
☐ Ski Patrol
☐ Other: _____

INJURY INFORMATION

PRIMARY INJURY RESULTING FROM INCIDENT
☐ Abrasion
☐ Allergy
☐ Amputation
☐ Burn
☐ Cardiac
☐ Cold Injury
☐ Concussion
☐ Contusion
☐ Dislocation
☐ Electric Shock
☐ Foreign Body
☐ Fracture
☐ Heat Exhaustion
☐ Hypertension
☐ Hypothermia
☐ Laceration
☐ Illness
☐ Nausea
☐ Pain
☐ Seizures
☐ Sting/Bite
☐ Strain/Sprain
☐ Stroke
☐ Tooth/Mouth
☐ Other: _____

BODY PART INJURED
☐ Ankle (L / R)
☐ Arm (L / R)
☐ Back
☐ Ear (L / R)
☐ Elbow (L / R)
☐ Eye (L / R)
☐ Face
☐ Finger or Toe
☐ Foot (L / R)
☐ Hand (L / R)
☐ Head
☐ Hip
☐ Internal
☐ Knee (L / R)
☐ Leg (L / R)
☐ Neck
☐ Nose
☐ Shoulder (L / R)
☐ Toe
☐ Tooth
☐ Torso
☐ Wrist (L / R)
☐ Other: _____

PLEASE COMPLETE 2ND PAGE

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

DESCRIPTION OF INCIDENT (continued). Include the following detailed information: Who was involved? Where were they? What happened? Any other circumstances? *Attach a separate sheet if necessary.*

PROCEDURES FOLLOWED AT TIME OF INCIDENT
Was medical treatment provided? ☐ No ☐ Yes *If yes, please continue answering questions below*
Who provided the treatment? (i.e. Ski Patrol, EMT)
Where was the treatment provided?
What treatment was provided?
Did injured individual go to the hospital? ☐ No ☐ Yes
If yes, where?
Any additional information?

WITNESS INFORMATION		
NAME	**ADDRESS**	**PHONE NUMBER**
1.		
2.		

REPORTER'S INFORMATION	
Name:	Position:
Email:	Phone Number:

Reporter's Signature _____ Date _____

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