



# Empire United Soccer Academy Accident Report

Player's Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Address: \_\_\_\_\_

Local Phone: \_\_\_\_\_ Gender: \_\_\_\_\_ Age: \_\_\_\_\_

### ACCIDENT DETAILS

Date: \_\_\_/\_\_\_/\_\_\_

Time: \_\_\_:\_\_\_ AM / PM

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

\_\_\_ Gym \_\_\_\_\_

\_\_\_ Other \_\_\_\_\_

Activity: \_\_\_\_\_

### HOW DID THE INJURY OCCUR?

- Collision w/ obstacle
- Collision w/ participant
- Collision w/ playing surface
- Equipment Related
- Non-Contact       Unknown
- Other (Describe – Use Back if Necessary)

\_\_\_\_\_  
\_\_\_\_\_

### FIRST AID ADMINISTERED BY

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Participant's Signature \_\_\_\_\_

### ACTION TAKEN

- Applied ice
- Stopped Bleeding
- Applied band-aid / bandage
- Other \_\_\_\_\_

(Describe specific steps – use back for more space)

### WITNESSES

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

### BODY PART INJURED (check applicable)

Left

Right

- |                                 |                                      |                                   |
|---------------------------------|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> Ankle  | <input type="checkbox"/> Foot        | <input type="checkbox"/> Mouth    |
| <input type="checkbox"/> Arm    | <input type="checkbox"/> Groin       | <input type="checkbox"/> Neck     |
| <input type="checkbox"/> Back   | <input type="checkbox"/> Hand        | <input type="checkbox"/> Nose     |
| <input type="checkbox"/> Ear    | <input type="checkbox"/> Head        | <input type="checkbox"/> Shoulder |
| <input type="checkbox"/> Elbow  | <input type="checkbox"/> Hip         | <input type="checkbox"/> Toe      |
| <input type="checkbox"/> Eye    | <input type="checkbox"/> Knee        | <input type="checkbox"/> Torso    |
| <input type="checkbox"/> Face   | <input type="checkbox"/> Leg         | <input type="checkbox"/> Wrist    |
| <input type="checkbox"/> Finger | <input type="checkbox"/> Other _____ |                                   |

### SUSPECTED INJURY CLASSIFICATION

- |   |                                      |
|---|--------------------------------------|
| <input type="checkbox"/> Concussion         | <input type="checkbox"/> Laceration  |
| <input type="checkbox"/> Contusion / Bruise | <input type="checkbox"/> Fracture    |
| <input type="checkbox"/> Sprain / Strain    | <input type="checkbox"/> Dislocation |
| <input type="checkbox"/> Other _____        |                                      |

### SUBSEQUENT ACTION TAKEN

Driven to \_\_\_\_\_ hospital by \_\_\_\_\_

- Sat out remainder of activity
- Resumed participation on own volition
- Resumed Participation after \_\_\_ minutes
- Other: \_\_\_\_\_
- Refused treatment

Participant's Parent's Signature \_\_\_\_\_

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Report Prepared By: \_\_\_\_\_

Position: \_\_\_\_\_