FSC wellness
developing mind body and spirit

Accident Report

Date of Accident: _____
Time of Accident: _____
Program Area: _____

Involved Participant Information

Name of participant: _____ Phone number: _____
ID number:_____ M / F DOB:_____
Circle one: Student Faculty Staff Guest Alumni Other: _____
Local address:_____ Email: _____
City: _____ State:_____ Zip:_____

If Under 18:

Parent's Name: _____ Parent's Phone Number: _____

If 911 is called

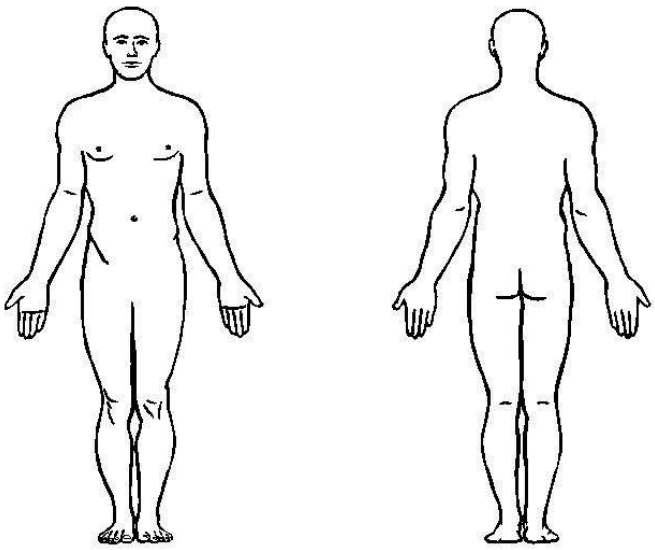
Time of Arrival of Ambulance:_____ Paramedic's Name: _____
Time of Departure of Ambulance: _____ Truck Number: _____
Was participant transported? YES / NO
If not transported, why?

_____
_____

If participant is an athlete

Athlete's sport: _____ Athlete's coach: _____
Was an athletic trainer called? YE S / NO
Did athlete continue practicing after accident occurred? YE S / NO

Circle and label the body part injured



Type of Injury:

___ Cut/Abrasion
___ Break/Sprain/Strain
___ Fainting/Dizziness
___ Dislocation
___ Vomit
___ Seizure
___ Breathing
___ Head/Neck/Back
___ Bloody/Broken Nose
___ Other

Please Describe

_____
_____
_____
_____
_____

Describe the accident:

_____

_____

_____

_____

What care was provided?

_____

_____

_____

_____

Refer to (check one):

___ Doctor ___ Hospital (ER)

___ FSC Health Center ___ Urgent Care

___ None

Was PPE used?	YES	/	NO
Were supplies disposed of/put away properly?	YES	/	NO
Was cleanup necessary?	YES	/	NO
Was area closed down?	YES	/	NO

Additional comments:

_____

_____

_____

_____

_____

Witness Information

Name of witness: _____ Phone number: _____

Email: _____

Witness Signature

_____ Date: _____ Time: _____

Participant's Signature

_____ Date: _____

Employee's Signature:

_____ Title: _____

Date: _____ Time: _____

Pro Staff Follow up

Report Reviewed By: _____ Title: _____

Date: _____ Time: _____

Additional comments:

_____

_____

_____