

Sports Injury Reporting Form

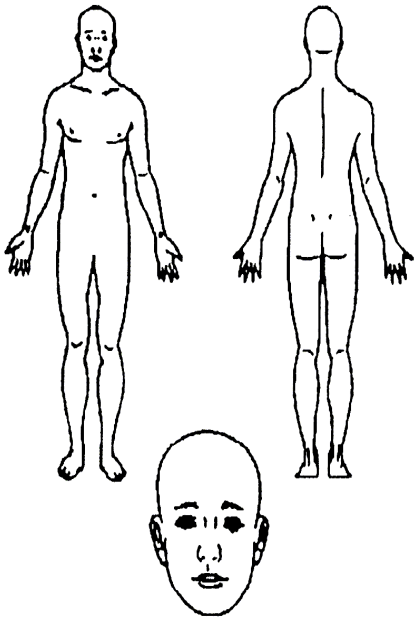


Name: _____ Address: _____

Sport: _____ Event: _____ Venue: _____ Team: _____

Today's date: ____/____/____ Time : ____ am/pm Gender: Male Female Date of Birth: ____/____/____

_____ Injured person (*please circle*): Player / Referee / Coach / Spectator

<p>TYPE OF ACTIVITY AT TIME OF INJURY</p> <p><input type="checkbox"/> training <input type="checkbox"/> warm-up <input type="checkbox"/> competition <input type="checkbox"/> cool-down <input type="checkbox"/> other _____</p> <p>REASON FOR PRESENTATION</p> <p><input type="checkbox"/> new injury <input type="checkbox"/> aggravated injury <input type="checkbox"/> recurrent injury <input type="checkbox"/> illness <input type="checkbox"/> other _____</p> <p>BODY PARTS INJURED <i>circle and name</i></p> <div style="text-align: center;">  </div> <p>NATURE OF INJURY/ILLNESS</p> <p><input type="checkbox"/> bruise/contusion <input type="checkbox"/> cardiac problem <input type="checkbox"/> cold/flu <input type="checkbox"/> concussion <input type="checkbox"/> dislocation/subluxation <input type="checkbox"/> fracture (including suspected) <input type="checkbox"/> inflammation/swelling <input type="checkbox"/> loss of consciousness <input type="checkbox"/> overuse injury <input type="checkbox"/> respiratory problem <input type="checkbox"/> skin injury e.g. graze/cut/blisters <input type="checkbox"/> sprain e.g. ligament tear <input type="checkbox"/> strain e.g. muscle tear <input type="checkbox"/> unspecified medical condition <input type="checkbox"/> other _____</p>	<p>CAUSE OF INJURY</p> <p><input type="checkbox"/> collision with fixed object <input type="checkbox"/> collision with another player <input type="checkbox"/> fall from height/awkward landing <input type="checkbox"/> jumping to shoot or defend <input type="checkbox"/> overexertion <input type="checkbox"/> overuse <input type="checkbox"/> slip/trip/fall/stumble <input type="checkbox"/> struck by ball/object <input type="checkbox"/> struck by another player <input type="checkbox"/> temperature related <input type="checkbox"/> other _____</p> <p>Explain how the incident occurred</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Were there any contributing factors to the incident? e.g. unsuitable footwear, playing surface, equipment, foul play</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Was protective equipment worn on the injured body part? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what? e.g. mouth guard, brace? _____</p> <p>_____</p> <p>ACTION TAKEN</p> <p><input type="checkbox"/> none given (not required) <input type="checkbox"/> CPR <input type="checkbox"/> dressing <input type="checkbox"/> immobilization <input type="checkbox"/> RICER <input type="checkbox"/> sling/splint <input type="checkbox"/> strapping/taping <input type="checkbox"/> stretch/exercises <input type="checkbox"/> transport from field/court <input type="checkbox"/> other _____</p>	<p>ADVICE GIVEN</p> <p><input type="checkbox"/> immediate return to activity <input type="checkbox"/> return to play with restriction _____</p> <p><input type="checkbox"/> unable to return at present <input type="checkbox"/> referred for further assessment before returning to activity</p> <p>NOTICE The injured person told that if injury/illness does NOT improve in the following 24 hours they MUST seek further advice from their own medical professional. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>REFERRAL</p> <p><input type="checkbox"/> no referral <input type="checkbox"/> medical practitioner <input type="checkbox"/> physiotherapist <input type="checkbox"/> ambulance <input type="checkbox"/> hospital <input type="checkbox"/> other _____</p> <p>PROVISIONAL SEVERITY ASSESSMENT</p> <p><input type="checkbox"/> mild (1 - 7 days modified activity) <input type="checkbox"/> moderate (8-21 days modified activity) <input type="checkbox"/> severe (>21 days modified or lost)</p> <p>TREATING PERSON</p> <p><input type="checkbox"/> Sports Trainer/Sports First Aider (ID _____) <input type="checkbox"/> medical practitioner <input type="checkbox"/> physiotherapist <input type="checkbox"/> other _____</p> <p>Signature of injured person _____</p> <p>Signature of treating person _____</p> <p>Date: ____/____/____</p>
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