

Incident Report Form



Date of report: ____/____/____
dd mm yyyy

PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____

STREET ADDRESS: _____

CITY: _____ PROVINCE: _____ POSTAL CODE: _____

PHONE: _____ E-MAIL: _____

AGE: _____ SEX: ___M___F HEIGHT: _____ WEIGHT: _____ DATE OF BIRTH: : ____/____/____
dd / mm / yyyy

KNOWN MEDICAL CONDITIONS/ALLERGIES: _____

INCIDENT INFORMATION

DATE OF INCIDENT: ____/____/____ TIME OF INCIDENT: ____ ____ AM/PM
dd mm yyyy

TIME OF FIRST INTERVENTION: ____ ____ AM/PM TIME OF MEDICAL SUPPORT ARRIVAL: ____ ____ AM/PM

EVENT/RACE ORGANIZER, DESCRIBE THE INCIDENT: (what took place, where it took place, what were the signs and symptoms of the patient)

PATIENT, DESCRIBE THE INCIDENT: (see above)

EVENT & CONDITIONS: (what was the event during which the incident took place, location of incident, surface quality, light, weather etc.):

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ACTIONS TAKEN/INTERVENTION:

After treatment, the patient was: Sent home / Sent to hospital/a clinic / Returned to activity

OTHER ORGANIZER / COACHING PERSON INFORMATION

LAST NAME: _____ FIRST NAME: _____

STREET ADDRESS: _____

CITY: _____ PROVINCE: _____ POSTAL CODE: _____

PHONE: _____ E-MAIL: _____

AGE : _____

ROLE (Coach, assistant, parent, official, bystander): _____

WITNESS INFORMATION (someone who observed the incident and the response)

LAST NAME: _____ FIRST NAME: _____

STREET ADDRESS: _____

CITY: _____ PROVINCE: _____ POSTAL CODE: _____

PHONE: _____ E-MAIL: _____

AGE: _____

OTHER COMMENTS OR REMARKS

FORM COMPLETED BY:

PRINT NAME

SIGNATURE