



# SBSC INCIDENT REPORT FORM

Return the completed form to SBSC official, program director or tournament director

Complete this form for:

1. Injuries
2. Incident – threats
3. Incident – fighting – any type
4. Property damage
5. Law enforcement summoned

<b>AFFECTED PARTY:</b> <input type="checkbox"/> Player <input type="checkbox"/> Official <input type="checkbox"/> Coach <input type="checkbox"/> Spectator <input type="checkbox"/> Volunteer <input type="checkbox"/> Other			
Last Name	First Name	MI	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address:			<b>Club Program</b>
City: State: Zip: Telephone Number: ( )			<input type="checkbox"/> In-Town <input type="checkbox"/> Travel
Does the injured person have other medical insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No			Birth Date:
If yes, please provide name of company and policy #: _____			Player Pass #:
Employer Name & Address:			

<b>GUARDIAN/PARENT (if affected party is a minor):</b>			
Last Name	First Name	MI	Telephone Number: ( )
Address:		City:	State: Zip:

<b>INCIDENT INFO:</b>	Date of Incident:	Age Division:	<input type="checkbox"/> Boys <input type="checkbox"/> Girls	Time of Incident: AM / PM
Event & Location:				
Team Involved #1:			Coach Name:	
Team Involved #2:			Coach Name:	

<b>BODY PART INJURED</b>	<b>If ankle injury, was ankle:</b>	<b>PRIMARY INJURY</b>
<input type="checkbox"/> Ankle (L/R) <input type="checkbox"/> Shoulder(L/R) <input type="checkbox"/> Tooth <input type="checkbox"/> Knee (L/R) <input type="checkbox"/> Wrist (L/R) <input type="checkbox"/> Back <input type="checkbox"/> Leg <input type="checkbox"/> Finger <input type="checkbox"/> Neck <input type="checkbox"/> Foot <input type="checkbox"/> Eye (L/R) <input type="checkbox"/> Internal <input type="checkbox"/> Toe <input type="checkbox"/> Ear (L/R) <input type="checkbox"/> No injury <input type="checkbox"/> Arm <input type="checkbox"/> Nose <input type="checkbox"/> Other <input type="checkbox"/> Hand <input type="checkbox"/> Head	<input type="checkbox"/> Taped/Supported <input type="checkbox"/> Unsupported Shoes: <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>If knee injury, was knee:</b> <input type="checkbox"/> Braced/Supported <input type="checkbox"/> Unsupported Knee Pads: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Abrasion <input type="checkbox"/> Dislocation <input type="checkbox"/> Pain <input type="checkbox"/> Burn <input type="checkbox"/> Foreign Body <input type="checkbox"/> Seizures <input type="checkbox"/> Cardiac <input type="checkbox"/> Fracture <input type="checkbox"/> Sting/Bite <input type="checkbox"/> Cold Injury <input type="checkbox"/> Heat Exhaustion <input type="checkbox"/> Strain/Sprain <input type="checkbox"/> Concussion <input type="checkbox"/> Laceration <input type="checkbox"/> Contusion <input type="checkbox"/> Nausea

<b>LOCATION</b>	<b>INCIDENT</b>	<b>DISPOSITION</b>
<input type="checkbox"/> Before Competition/Event <input type="checkbox"/> During Competition/Event <input type="checkbox"/> After Competition/Event <input type="checkbox"/> Competition Area <input type="checkbox"/> Concession Area <input type="checkbox"/> Parking Lot <input type="checkbox"/> Restrooms <input type="checkbox"/> Off Property <input type="checkbox"/> Bleachers/Stands	<input type="checkbox"/> Collision (participant/spectator) <input type="checkbox"/> Collision (with object) <input type="checkbox"/> Collision (participant/participant) <input type="checkbox"/> Collision (spectator/spectator) <input type="checkbox"/> Struck by falling /flying object <input type="checkbox"/> Caught in, on, between goal  Notes:	<i>No care given:</i> <input type="checkbox"/> Not Needed <input type="checkbox"/> Patient Refused  <i>Released:</i> <input type="checkbox"/> To Parent <input type="checkbox"/> To Personal Vehicle  <i>Referral:</i> <input type="checkbox"/> To Doctor <input type="checkbox"/> To Hospital/Clinic  <i>EMS transport:</i> <input type="checkbox"/> Region Recommended <input type="checkbox"/> Patient/Parent Requested

<b>FIELD SURFACE</b>	<b>CLASSIFICATION</b>
<input type="checkbox"/> Dirt <input type="checkbox"/> Grass <input type="checkbox"/> Indoor <input type="checkbox"/> Field Turf <input type="checkbox"/> Astro Turf	<input type="checkbox"/> Non-Injury (threat, assault) <input type="checkbox"/> Minor Injury or Illness <input type="checkbox"/> Serious Injury or Illness

<b>POLICE REPORT FILED:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, report number: _____ Officer's Name & badge #: _____
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**Describe how the incident, injury or property damage occurred: (use the backside or attach a separate sheet if necessary – may attach a copy of the Referee Game Misconduct Report)**

WITNESS INFORMATION – Confidential		
Name	Address	Telephone Number

Person/volunteer completing/submitting this form:

Name:	Signature:	Ph: ( )
Position Title:	E-mail address:	Date: