



SPORT _____

ACCIDENT/INJURY REPORT – SPORT CLUBS

Campus Police (413) 545-2121

If Campus Police is called for an injury, they will call an ambulance

Emergency 911

University Health Services (413) 577-5000

PERSONAL INFORMATION

Name _____ SPIRE # _____

Address _____ Phone _____

Email: _____ Age/Gender ____/____ Status _____
(UGrad, Grad, Fac/Staff, Visitor Other)

Team _____ President (Name, Phone, Email) _____

DETAILS OF ACCIDENT/INJURY

Date _____ Time _____ Location _____

Witness(es) _____ Phone _____

How did accident/injury occur? _____

SUSPECTED INJURIES	
<i>Check all that apply</i>	
<input type="checkbox"/> Abrasion	<input type="checkbox"/> Laceration
<input type="checkbox"/> Bleeding	<input type="checkbox"/> Puncture
<input type="checkbox"/> Bruise/Contusion	<input type="checkbox"/> Scratches
<input type="checkbox"/> Burn	<input type="checkbox"/> Shock
<input type="checkbox"/> Concussion	<input type="checkbox"/> Sprain
<input type="checkbox"/> Cramps _____	<input type="checkbox"/> Strain
<input type="checkbox"/> Dislocation	<input type="checkbox"/> Suffocation
<input type="checkbox"/> Fainting	<input type="checkbox"/> Other _____
<input type="checkbox"/> Fracture	_____
<input type="checkbox"/> Internal Injury	_____

AREA OF INJURY		
<i>Check all that apply</i>		
<input type="checkbox"/> Abdomen	<input type="checkbox"/> Foot L R	<input type="checkbox"/> Ribs L R
<input type="checkbox"/> Ankle L R	<input type="checkbox"/> Hand L R	<input type="checkbox"/> Shoulder L R
<input type="checkbox"/> Arm L R	<input type="checkbox"/> Head	<input type="checkbox"/> Thigh L R
<input type="checkbox"/> Back L R	<input type="checkbox"/> Hip L R	<input type="checkbox"/> Toe L R
<input type="checkbox"/> Chest L R	<input type="checkbox"/> Knee L R	<input type="checkbox"/> Tooth
<input type="checkbox"/> Ear L R	<input type="checkbox"/> Jaw	<input type="checkbox"/> Wrist L R
<input type="checkbox"/> Elbow L R	<input type="checkbox"/> Leg L R	
<input type="checkbox"/> Eye L R	<input type="checkbox"/> Mouth	
<input type="checkbox"/> Face	<input type="checkbox"/> Neck	
<input type="checkbox"/> Finger L R	<input type="checkbox"/> Nose	

ACTION TAKEN
<input type="checkbox"/> First aid (describe action taken) _____

<input type="checkbox"/> Injured patron went to UHS by him/herself
<input type="checkbox"/> Transported to UHS by _____
<input type="checkbox"/> Ambulance called by _____
<input type="checkbox"/> Other _____
<input type="checkbox"/> Injured declined first aid
_____ patron signature
_____ date/time

STAFF INFORMATION
Injury care provider or EMT _____
<i>Contact info</i> _____
Officials _____
<i>Contact info</i> _____
Professional Staff Review

Name _____ Date _____