



Empire United Soccer Academy Accident Report

Player's Name: _____ Today's Date: _____

Address: _____

Local Phone: _____ Gender: _____ Age: _____

ACCIDENT DETAILS

Date: ___/___/___

Time: ___:___ AM / PM

Location: _____

___ Gym _____

___ Other _____

Activity: _____

HOW DID THE INJURY OCCUR?

- Collision w/ obstacle
- Collision w/ participant
- Collision w/ playing surface
- Equipment Related
- Non-Contact Unknown
- Other (Describe – Use Back if Necessary)

FIRST AID ADMINISTERED BY

Name: _____

Phone: _____

Participant's Signature _____

ACTION TAKEN

- Applied ice
- Stopped Bleeding
- Applied band-aid / bandage
- Other _____

(Describe specific steps – use back for more space)

WITNESSES

Name: _____

Phone: _____

BODY PART INJURED (check applicable)

Left

Right

- | | | |
|---------------------------------|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> Ankle | <input type="checkbox"/> Foot | <input type="checkbox"/> Mouth |
| <input type="checkbox"/> Arm | <input type="checkbox"/> Groin | <input type="checkbox"/> Neck |
| <input type="checkbox"/> Back | <input type="checkbox"/> Hand | <input type="checkbox"/> Nose |
| <input type="checkbox"/> Ear | <input type="checkbox"/> Head | <input type="checkbox"/> Shoulder |
| <input type="checkbox"/> Elbow | <input type="checkbox"/> Hip | <input type="checkbox"/> Toe |
| <input type="checkbox"/> Eye | <input type="checkbox"/> Knee | <input type="checkbox"/> Torso |
| <input type="checkbox"/> Face | <input type="checkbox"/> Leg | <input type="checkbox"/> Wrist |
| <input type="checkbox"/> Finger | <input type="checkbox"/> Other _____ | |

SUSPECTED INJURY CLASSIFICATION

- | | |
|---|--------------------------------------|
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Laceration |
| <input type="checkbox"/> Contusion / Bruise | <input type="checkbox"/> Fracture |
| <input type="checkbox"/> Sprain / Strain | <input type="checkbox"/> Dislocation |
| <input type="checkbox"/> Other _____ | |

SUBSEQUENT ACTION TAKEN

Driven to _____ hospital by _____

- Sat out remainder of activity
- Resumed participation on own volition
- Resumed Participation after ___ minutes
- Other: _____
- Refused treatment

Participant's Parent's Signature _____

Name: _____

Phone: _____

Report Prepared By: _____

Position: _____