

**SOUTHWESTERN INTRAMURAL & RECREATIONAL ACTIVITIES
ACCIDENT REPORT FORM**

Date of Report ___/___/___ **Date of Injury** ___/___/___ **Time of Injury** _____ a.m. p.m.

Information on Injured Person	
Name: _____	
Address: _____	
(street number)	(city)
(state)	(zip code)
Phone: _() _____	Social security Number: _____
Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth: ___/___/___
Classification: <input type="checkbox"/> Student <input type="checkbox"/> Faculty <input type="checkbox"/> Staff <input type="checkbox"/> Spouse <input type="checkbox"/> Alumni <input type="checkbox"/> Guest <input type="checkbox"/> Other (specify) _____	

POSSIBLE TYPE OF INJURY: SPRAIN STRAIN FRACTURE DISLOCATION CONCUSSION
 CONTUSION LACERATION PUNCTURE BLISTER OTHER (SPECIFY) _____

BODY PART INJURED: **RIGHT** **LEFT**

<input type="checkbox"/> HEAD	<input type="checkbox"/> JAW	<input type="checkbox"/> UPPER BACK	<input type="checkbox"/> HIP	<input type="checkbox"/> ELBOW	<input type="checkbox"/> THIGH (Hamstring)	<input type="checkbox"/> ANKLE
<input type="checkbox"/> FOREHEAD	<input type="checkbox"/> EAR	<input type="checkbox"/> LOWER BACK	<input type="checkbox"/> GROIN	<input type="checkbox"/> FOREARM	<input type="checkbox"/> THIGH (QUADRICEP)	<input type="checkbox"/> HEEL
<input type="checkbox"/> EYEBROW	<input type="checkbox"/> NECK	<input type="checkbox"/> CHEST	<input type="checkbox"/> TAILBONE	<input type="checkbox"/> WRIST	<input type="checkbox"/> KNEE	<input type="checkbox"/> TOP OF FOOT
<input type="checkbox"/> EYE	<input type="checkbox"/> THROAT	<input type="checkbox"/> RIBS	<input type="checkbox"/> BUTTOCK	<input type="checkbox"/> PALM OF HAND	<input type="checkbox"/> SHIN	<input type="checkbox"/> BOTTOM OF FOOT
<input type="checkbox"/> NOSE	<input type="checkbox"/> COLLARBONE	<input type="checkbox"/> STERNUM	<input type="checkbox"/> BICEP	<input type="checkbox"/> BACK OF HAND	<input type="checkbox"/> CALF	<input type="checkbox"/> TOE (WHICH)
<input type="checkbox"/> MOUTH	<input type="checkbox"/> SHOULDER	<input type="checkbox"/> STOMACH	<input type="checkbox"/> TRICEP	<input type="checkbox"/> FINGER (WHICH)	_____	

FACILITY WHERE UNJURY OCCURRED:

ROBERTSON CENTER:	OTHER AREAS:
<input type="checkbox"/> WALZEL GYM	<input type="checkbox"/> TENNIS COURTS
<input type="checkbox"/> ROBERTSON GYM	<input type="checkbox"/> SOFTBALL FIELD
<input type="checkbox"/> WEIGHT ROOM	<input type="checkbox"/> BASEBALL FIELD
<input type="checkbox"/> AEROBICS ROOM	<input type="checkbox"/> SNYDER FIELD
<input type="checkbox"/> TRACK	<input type="checkbox"/> MOSES FIELD
<input type="checkbox"/> POOL	<input type="checkbox"/> ACADEMIC MALL
<input type="checkbox"/> LOCKER ROM	<input type="checkbox"/> RACQUETBALL COURT
<input type="checkbox"/> OTHER _____	<input type="checkbox"/> OTHER _____

PROGRAM AND ACTIVITY DURING WHICH INJURY OCCURRED:

<input type="checkbox"/> INTRAMURAL SPORTS (SPECIFY SPORT) _____	<input type="checkbox"/> SPORT CLUB (SPECIFY CLUB) _____
<input type="checkbox"/> FITNESS PROGRAM (SPECIFY PROGRAM) _____	<input type="checkbox"/> SPECIAL EVENT (SPECIFY EVENT) _____
<input type="checkbox"/> OTHER (SPECIFY PROGRAM AREA AND ACTIVITY) _____	<input type="checkbox"/> OUTDOOR RECREATION (SPECIFY ACTIVITY) _____

SPECIFIC DESCRIPTION OF HOW THE INJURY OCCURRED: _____

WHAT CARE WAS PROVIDED AND WHAT ACTION WAS TAKEN FOR THE INJURED PERSON? (BE DETAILED) _____

WAS CAMPUS POLICE NOTIFIED? YES NO **IF YES, NAME OF OFFICER RESPONDING** _____

DID PARAMEDICS/AMBULANCE RESPOND? YES NO **DID THE INJURED INDIVIDUAL CONTINUE TO PARTICIPATE?** YES NO

HOW WAS THE INJURED INDIVIDUAL TRANSPORTED (OR LEAVE THE FACILITY)? AMBULANCE CAMPUS POLICE FRIENDS SELF OTHER (SPECIFY) _____

WAS THE INJURED INDIVIDUAL ADVISED TO VISIT THE HEALTH CENTER OR SEEK OTHER MEDICAL TREATMENT? YES NO

WAS THE INJURED INDIVIDUAL ADVISED TO DISCONTINUE PARTICIPATION? YES NO

SIGNATURE OF INJURED: _____ **DATE:** _____ **WITNESS NAME:** _____

SIGNATURE OF PERSON FILING REPORT: _____ **WITNESS PHONE NUMBER:** _____

PRINTED NAME OF PERSON FILING REPORT: _____ **PHONE NUMBER:** _____

