



## Diocesan Recreation Association Incident Report



**Procedure:** To be completed for all incidents occurring on parish property, or in any parish activity that requires medical or dental attention. This form is to be completed by parish personnel supervising an activity, a nurse, or other appropriate individual. Report must be completed as soon after the incident as is practical, or upon return to parish by individual.

<b>A. To be completed for all incidents.</b>			
Name of Injured: _____		<input type="checkbox"/> Athlete	
Address: _____		Telephone No: _____	
_____		Location: _____	
Witness: _____		Telephone No: _____	
Date of Incident: _____		Time of Incident: _____ AM _____ PM	
<b>B. To be completed for athlete incidents only.</b>			
Parish: _____		Grade: _____	
Parents Notified? <input type="checkbox"/> Yes <input type="checkbox"/> No		Supervised Activity? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Person in charge: _____		Accident Location: <input type="checkbox"/> classroom <input type="checkbox"/> playground <input type="checkbox"/> gym <input type="checkbox"/> bus	
<input type="checkbox"/> Other, specify _____		Object or Surface condition: <input type="checkbox"/> dry <input type="checkbox"/> slippery <input type="checkbox"/> wet <input type="checkbox"/> rough <input type="checkbox"/> ice/snow <input type="checkbox"/> moving <input type="checkbox"/> cracked/broken	
<input type="checkbox"/> stationary <input type="checkbox"/> uneven/raised			
<b>C. Type of Injury.</b>			
<input type="checkbox"/> Abrasion	<input type="checkbox"/> Concussion	<input type="checkbox"/> Fracture	<input type="checkbox"/> Sprain
<input type="checkbox"/> Bruise	<input type="checkbox"/> Cut	<input type="checkbox"/> Laceration	<input type="checkbox"/> Strain
<input type="checkbox"/> Burn	<input type="checkbox"/> Dislocation	<input type="checkbox"/> Puncture	Other _____
<b>D. Part of the body involved.</b>			
left	right	left	right
<input type="checkbox"/> chest	<input type="checkbox"/>	<input type="checkbox"/> neck	<input type="checkbox"/>
<input type="checkbox"/> back	<input type="checkbox"/>	<input type="checkbox"/> teeth	<input type="checkbox"/>
<input type="checkbox"/> abdomen	<input type="checkbox"/>	<input type="checkbox"/> face	<input type="checkbox"/>
<input type="checkbox"/> groin	<input type="checkbox"/>	<input type="checkbox"/> eye	<input type="checkbox"/>
<input type="checkbox"/> ear	<input type="checkbox"/>	<input type="checkbox"/> nose	<input type="checkbox"/>
<input type="checkbox"/> fingers	<input type="checkbox"/>	<input type="checkbox"/> ankle	<input type="checkbox"/>
left	right	left	right
<input type="checkbox"/> shoulder	<input type="checkbox"/>	<input type="checkbox"/> hip	<input type="checkbox"/>
<input type="checkbox"/> upper arm	<input type="checkbox"/>	<input type="checkbox"/> upper leg	<input type="checkbox"/>
<input type="checkbox"/> lower arm	<input type="checkbox"/>	<input type="checkbox"/> lower leg	<input type="checkbox"/>
<input type="checkbox"/> elbow	<input type="checkbox"/>	<input type="checkbox"/> knee	<input type="checkbox"/>
<input type="checkbox"/> scalp	<input type="checkbox"/>	<input type="checkbox"/> toes	<input type="checkbox"/>
<input type="checkbox"/> mouth	<input type="checkbox"/>	<input type="checkbox"/> hand	<input type="checkbox"/>
<b>E. Cause of Incident.</b>			
<input type="checkbox"/> Animal/Insect bite	<input type="checkbox"/> Collision with person	<input type="checkbox"/> Toxic substance	<input type="checkbox"/> Fighting
<input type="checkbox"/> Struck by vehicle	<input type="checkbox"/> Struck by object	<input type="checkbox"/> Collision with object	<input type="checkbox"/> Lifting
<input type="checkbox"/> Exposure to weather	<input type="checkbox"/> Exposure to blood	<input type="checkbox"/> Hot surface/substance	<input type="checkbox"/> Slip/trip/fall
<input type="checkbox"/> Caught on or in between	<input type="checkbox"/> Fall different level	<input type="checkbox"/> Other, specify _____	

Comments: \_\_\_\_\_  
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