



Incident/Accident Report – *If more space is needed, attach additional pages*

Date of incident:	Time of incident: AM / PM
Name of person submitting this report:	
Phone number:	Email:

INJURED PERSON INFORMATION:

Name of injured person:			
Guardian/parent (if injured is a minor):			
Address:			
City, State, Zip:			
Phone number:		Email address:	
Age:	DOB:	Male / Female	Has medical insurance? YES / NO

RELATIONSHIP OF INJURED PERSON TO AMSEA:

<input type="checkbox"/> Student/course participant	<input type="checkbox"/> Employee	<input type="checkbox"/> Volunteer
<input type="checkbox"/> Paid contract instructor	<input type="checkbox"/> Board member	<input type="checkbox"/> Spectator
<input type="checkbox"/> Other (explain):		

WHEN DID INCIDENT OCCUR?

<input type="checkbox"/> During training/event	Describe type of training or event:	
<input type="checkbox"/> Before training/event began	<input type="checkbox"/> After training/event	<input type="checkbox"/> While traveling
<input type="checkbox"/> Other (explain):		

WHERE DID INCIDENT TAKE PLACE?

<input type="checkbox"/> AMSEA office	<input type="checkbox"/> AMSEA grounds/parking area	<input type="checkbox"/> AMSEA storage area
<input type="checkbox"/> Training classroom - offsite	Describe classroom location:	
<input type="checkbox"/> Outdoor training site	Describe site:	
<input type="checkbox"/> Other	Describe other location:	

TYPE OF INCIDENT:

<input type="checkbox"/> Assault, nonsexual	<input type="checkbox"/> Sexual assault	<input type="checkbox"/> Fall onto hard surface	<input type="checkbox"/> Slip/fall
<input type="checkbox"/> Caught in/on/between	<input type="checkbox"/> Animal/insect bite	<input type="checkbox"/> Fall into water	<input type="checkbox"/> In-water incident
<input type="checkbox"/> Caught in/on/between	<input type="checkbox"/> Automobile accident	<input type="checkbox"/> Boating accident	<input type="checkbox"/> Overexertion
<input type="checkbox"/> Bodily collision with object		<input type="checkbox"/> Bodily collision with another person	
<input type="checkbox"/> Struck by falling/flying object		<input type="checkbox"/> Fire/flare incident	
<input type="checkbox"/> Other (explain):			

PRIMARY APPARENT INJURY:

<input type="checkbox"/> Allergy	<input type="checkbox"/> Amputation	<input type="checkbox"/> Abrasion	<input type="checkbox"/> Cold injury	<input type="checkbox"/> Death
<input type="checkbox"/> Dislocation	<input type="checkbox"/> Laceration	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Drowning	<input type="checkbox"/> Seizure
<input type="checkbox"/> Strain/sprain	<input type="checkbox"/> Electrical shock	<input type="checkbox"/> Foreign body	<input type="checkbox"/> Fracture	<input type="checkbox"/> Heat exhaustion
<input type="checkbox"/> Cardiac arrest	<input type="checkbox"/> Concussion	<input type="checkbox"/> Contusion	<input type="checkbox"/> Tooth/mouth	<input type="checkbox"/> Nausea
<input type="checkbox"/> Stroke	<input type="checkbox"/> Burn	<input type="checkbox"/> Pain	<input type="checkbox"/> Sting/bite	<input type="checkbox"/> Illness

SUSPECTED PRE-EXISTING CONDITION? YES NO

BODY PART INJURED:

<input type="checkbox"/> Knee L / R	<input type="checkbox"/> Shoulder L / R	<input type="checkbox"/> Elbow L / R	<input type="checkbox"/> Wrist L / R	<input type="checkbox"/> Leg L / R
<input type="checkbox"/> Ankle L / R	<input type="checkbox"/> Hip L / R	<input type="checkbox"/> Foot L / R	<input type="checkbox"/> Hand L / R	<input type="checkbox"/> Arm L / R
<input type="checkbox"/> Torso	<input type="checkbox"/> Back	<input type="checkbox"/> Toe	<input type="checkbox"/> Finger	<input type="checkbox"/> Tooth
<input type="checkbox"/> Head	<input type="checkbox"/> Face	<input type="checkbox"/> Eye L / R	<input type="checkbox"/> Nose	<input type="checkbox"/> Neck

MEDICAL SERVICES PROVIDED:

Name of person providing treatment:				
<input type="checkbox"/> Antacid	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Aspirin substitute	<input type="checkbox"/> Bandage	<input type="checkbox"/> Glucose
<input type="checkbox"/> CPR	<input type="checkbox"/> Cleanse	<input type="checkbox"/> Cold/ice pack	<input type="checkbox"/> Heat pack	<input type="checkbox"/> Eye rinse
<input type="checkbox"/> Oxygen	<input type="checkbox"/> Rest	<input type="checkbox"/> Splint	<input type="checkbox"/> Wrap	<input type="checkbox"/> Exam
<input type="checkbox"/> Ointment/antiseptic			<input type="checkbox"/> Removal of foreign object	<input type="checkbox"/> None

OUTCOME (check all that apply):

<input type="checkbox"/> Released to parent	<input type="checkbox"/> Refused care	<input type="checkbox"/> Suggested medical care be sought
<input type="checkbox"/> Released on own	<input type="checkbox"/> EMS/ambulance transport	<input type="checkbox"/> Police assistance
<input type="checkbox"/> Medical care on-site	<input type="checkbox"/> Private transport to medical facility	<input type="checkbox"/> Report only

ON THE BACK OF THIS FORM, DESCRIBE HOW INCIDENT OCCURRED AND PROVIDE ANY OTHER PERTINENT INFORMATION