



MSC INCIDENT REPORT FORM

Use in the event of Injury, Incident or Property Damage

INJURED PERSON INFORMATION/PROPERTY DAMAGE OWNER:

Last Name _____ First Name _____ MI _____ Telephone: _____
 Address: _____ Player Pass # _____
 City: _____ State: _____ Zip: _____ Age: _____ D.O.B.: _____
 Team Name: _____ Division: _____ Gender: ☐ Male ☐ Female

Does the injured person have other medical insurance? ☐ Yes ☐ No If yes, please provide name of company and policy #: _____

INJURED PERSON: ☐ Player ☐ Official ☐ Coach ☐ Spectator ☐ Volunteer ☐ Other: _____

GUARDIAN/PARENT (if injured person is a minor):

Last Name _____ First Name _____ MI _____ Telephone Number: _____
 Address: _____ City: _____ State: _____ Zip: _____

INCIDENT INFORMATION: Date of Incident: _____ Time of Incident: _____ AM / PM

BODY PART INJURED _ Nose _ Head _ Tooth _ Ankle (L/R) _ Knee (L/R) _ Shoulder (L/R) _ Wrist (L/R) _ Finger _ Eye (L/R) _ Ear (L/R) _ Back _ Neck _ Internal _ No injury _ Other	PRIMARY INJURY _ Abrasion _ Burn _ Cardiac _ Cold Injury _ Concussion _ Contusion _ Dislocation _ Foreign Body _ Fracture _ Heat Exhaustion _ Nausea _ Laceration _ Pain _ Seizures _ Sting/Bite _ Strain/Sprain	If ankle injury, was ankle: _ Taped/Supported _ Unsupported Shoes: _ Yes _ No If knee injury, was knee: _ Braced/Supported _ Unsupported Knee Pads: _ Yes _ No FIELD SURFACE _ Dirt _ Grass _ Indoor CLASSIFICATION _ Non-Injury _ Minor Injury or Illness _ Serious Injury or Illness	<u>INCIDENT</u> _ Collision (participant/spectator) _ Collision (with object) _ Collision (participant/participant) _ Collision (spectator/spectator) _ Struck by falling /flying object _ Caught in, on, between goal _ Animal/insect bite/sting _ Slip/Fall _ Overexertion _ Assault/Sexual _ Assault/Non-Sexual _ Property Damage
<u>LOCATION</u> _ Before Competition/Event _ During Competition/Event _ After Competition/Event _ Competition Area _ Concession Area _ Parking Lot _ Restrooms _ Off Property	<u>DISPOSITION</u> No care given: _____ Not Needed Released: _____ Patient Refused Referral: _____ To Parent _____ To Personal Vehicle _____ To Doctor _____ To Hospital/Clinic EMS transport: _____ Coach Recommended _____ Patient/Parent Requested	POLICE REPORT FILED: _ Yes _ No If yes, report number: _____ Officer's Name: _____ City, State: _____ Extra info: _____	

Describe how the incident, injury or property damage occurred: (use the backside or attach a separate sheet if necessary)

WITNESS Name(s)	Address	Telephone Number
_____	_____	_____
_____	_____	_____

Person completing this form:

Name: _____ Signature: _____ Date: _____ Phone: _____
This report is to be signed and submitted to the Coach or Safety Administrator within 48 hours of incident