

ACCIDENT INCIDENT REPORT FORM LACROSSE

PLEASE COMPLETE THIS FORM WHENEVER A LACROSSE ACCIDENT OCCURS WHICH REQUIRES SOME FORM OF MEDICAL ATTENTION. INCLUDES ATHLETES, OFFICIALS, COACHES AND VOLUNTEERS, ETC. THIS FORM MUST ACCOMPANY ANY MEDICAL OR DENTAL CLAIM.

SEND IMMEDIATELY TO:

ONTARIO LACROSSE ASSOCIATION
3 Concorde Gate, Suite 306
Toronto, On M3C 3N7

Phone: (416) 426-7066 Fax: (416) 426-7382

The information which you provide on this form allows us to establish causes of and types of injuries related to lacrosse as part of a long term research effort to improve preventative measures.

Please indicate activity in which injured person was participating:

- Practice
- Game
- Sanctioned Tournament
- Non-Sanctioned Tournament

Please state whether the activity was: Indoor Outdoor

Name of Injured Person: _____
Surname Given Name

Address: _____

City: _____ Province: _____ Postal Code _____

Phone # () _____ Age _____ Date of Birth _____ Male ___ Female ___

Date of Accident _____ Location of Accident _____

Club Name _____ Address _____

Team Name _____ League Name _____

Age Group: Under 18 _____ Over 18 _____

PLEASE CHECK APPROPRIATE BOX TO DESCRIBE ACCIDENT:

- | | |
|--|--|
| <input type="checkbox"/> Collision with another player | <input type="checkbox"/> Hit with stick |
| <input type="checkbox"/> Collision with goalie | <input type="checkbox"/> Hit with ball |
| <input type="checkbox"/> Collision with net | <input type="checkbox"/> Hit from behind |
| <input type="checkbox"/> Collision with boards | <input type="checkbox"/> Jumping over player |
| <input type="checkbox"/> Trip (no contact) | <input type="checkbox"/> Surface problem |

If hit with stick, what type of stick: Plastic stick Wood stick

Was a foul called: YES NO

Against you: YES NO

What Infraction:

- | | | |
|---|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Fighting | <input type="checkbox"/> Roughing | <input type="checkbox"/> Tripping |
| <input type="checkbox"/> Dangerous play | <input type="checkbox"/> Tackling | <input type="checkbox"/> Other _____ |

PLEASE CHECK EQUIPMENT INJURED PERSON WAS WEARING:

- | | | |
|---|--|--|
| <input type="checkbox"/> Helmet no mask | <input type="checkbox"/> Kidney pads | <input type="checkbox"/> Shin pads |
| <input type="checkbox"/> Helmet full mask | <input type="checkbox"/> Shoulder pads | <input type="checkbox"/> Knee pads |
| <input type="checkbox"/> Full mouth guard | <input type="checkbox"/> Elbow pads | <input type="checkbox"/> Lacrosse gloves |
| <input type="checkbox"/> Other gloves | | |

PLEASE INDICATE TYPE OF INJURY: (this accident)

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Dental | <input type="checkbox"/> Concussion | <input type="checkbox"/> Fracture | <input type="checkbox"/> Bruise |
| <input type="checkbox"/> Muscle pull | <input type="checkbox"/> Sprain (joints) | <input type="checkbox"/> Internal Injury | <input type="checkbox"/> Skin (wound/puncture) |
| <input type="checkbox"/> Torn ligament | <input type="checkbox"/> Dislocation | <input type="checkbox"/> Laceration | <input type="checkbox"/> Torn cartilage |

PLEASE INDICATE THE BODY PARTS INJURED: (this accident)

- | | | | | | |
|--------------------------------------|------------------------------------|--------------------------------|--------------------------------------|--------------------------------|--|
| <input type="checkbox"/> Knee | <input type="checkbox"/> Hip | <input type="checkbox"/> Teeth | <input type="checkbox"/> Hand | <input type="checkbox"/> Ankle | <input type="checkbox"/> Back |
| <input type="checkbox"/> Face | <input type="checkbox"/> Fingers | <input type="checkbox"/> Foot | <input type="checkbox"/> Spine | <input type="checkbox"/> Neck | <input type="checkbox"/> Upper arm |
| <input type="checkbox"/> Chest | <input type="checkbox"/> Chin | <input type="checkbox"/> Wrist | <input type="checkbox"/> Thigh | <input type="checkbox"/> Eye | <input type="checkbox"/> Achilles Tendon |
| <input type="checkbox"/> Nose | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Elbow | <input type="checkbox"/> Head | <input type="checkbox"/> Calf | <input type="checkbox"/> Collar bone |
| <input type="checkbox"/> Ear | <input type="checkbox"/> Hamstring | <input type="checkbox"/> Thumb | <input type="checkbox"/> Mid Section | | |
| <input type="checkbox"/> Other _____ | | | | | |

LACROSSE ACTIVITY: (this accident)

A) FIELD LACROSSE:

Position played: Forward Goal

This accident happened in the:

1st quarter 2nd quarter 3rd quarter 4th quarter

B) BOX LACROSSE:

Position played: Middle Attack Defense Goal Keeper

This accident happened in the: 1st period 2nd period 3rd period

OTHER CONDITIONS:

GAME PLAYED: Morning Afternoon Evening

WEATHER CONDITIONS: Sunny Cloudy Rain
 Other _____

TEMPERATURE - CELCIUS:

Below 0 0-10 10-20 20-25 26-33 plus 33

PLAYING SURFACE:

Wood Grass Concrete Rubberized Artificial Turf
 Other _____

LOCATION:

Gymnasium Community Centre Arena School

HOW LONG HAS INDIVIDUAL BEEN ACTIVE IN LACROSSE:

As a player _____ years As a coach _____ years As a referee _____ years

WAS INJURED PERSON TREATED ON SITE OR REFERRED FOR PROFESSIONAL MEDICAL/DENTAL TREATMENT?

On Site: Yes No

If "yes", treated by whom?

_____ Name

_____ Position

Professional medical/dental treatment? Yes No

If "yes" Name of **Witness**: _____

Full Address: _____

Phone Number: () _____

Submitted by (Signature)

Address

Position

Date

NOTE: IF MAJOR ACCIDENT, REQUIRE FULL WITNESS REPORTS AS WELL AS ALL OTHER REPORTS TO BE FORWARDED WITHIN TWENTY-FOUR (24) HOURS.

Place an "X" at area of injury

Place an "O" at your net

Indicate if it was:

Box Lacrosse

Field Lacrosse

A large rectangular box for drawing the injury site. It contains two horizontal lines, one near the top and one near the bottom, likely representing the net or goal area.