



Pickering Football Club / Pickering Soccer Centre Special Incident & Injury Reporting Form

This **MUST** be completed by a team representative at the time of an incident/injury during a Club sanctioned game or practice, either outdoors or indoors. Completed forms can be provided to PFC via email to execdirector@pickeringfc.ca or via fax at 905-239-0067, or dropped off in person at the Pickering Soccer Centre at 1975 Clements Road, Pickering, ON L1V 4C2.

For incidents occurring inside the Pickering Soccer Centre, the form is to be completed with and left with Facility staff present at the time of the incident.

Please Note:

- Referee Special Incident Reports are NOT to be done on this form.
- Injury Claims for accidents, meaning, injuries incurred during a sanctioned game for which an insurance claim is being made, are NOT to be done on this form.

Details – PLEASE PRINT!	
Type of Incident: <input type="checkbox"/> Injury <input type="checkbox"/> Altercation (Physical or Verbal) <input type="checkbox"/> Theft <input type="checkbox"/> Vandalism <input type="checkbox"/> Other	
Location of Occurrence:	Age Group:
Occurrence Date:	Occurrence Time:
Event: <input type="checkbox"/> Camp <input type="checkbox"/> Game <input type="checkbox"/> Practice <input type="checkbox"/> Exhibition <input type="checkbox"/> Other (specify):	
Reported by:	Phone/Email:
Was a parent/guardian contacted: <input type="checkbox"/> Yes <input type="checkbox"/> No If No, why not:	

List the name(s) of the person(s) involved and indicate their role in the incident (i.e.: player, coach, manager, trainer, club official, spectator, witness, or other (specify):		
Name	Role	Contact #

Describe the incident/injury in detail:

Was First Aid offered: <input type="checkbox"/> Yes <input type="checkbox"/> No	Was First Aid Administered: <input type="checkbox"/> Yes <input type="checkbox"/> No
If administered, by Whom (<i>print name</i>):	
Describe treatment:	
If medical treatment declined, have injured party/guardian sign here:	
Was 911 called: <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, Badge/Truck Number:
Injured party released to: <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> EMS <input type="checkbox"/> Other	
If released to EMS, which hospital was party taken to:	

Report Completed By (<i>print name</i>):	
Date:	Time:

Continue to back of page if more room is required.