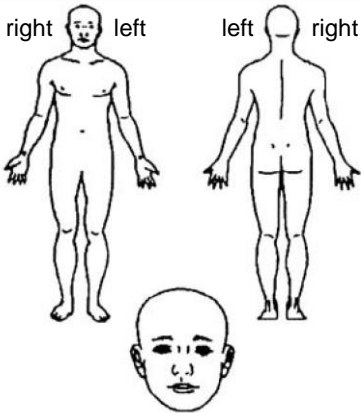


# Injury report form

Injury details: <i>This report reflects an accurate record of the injured person's reported symptoms of injury</i>		
Name of person injured:	DOB: / / (Day/Month/Year)	
Date when injury occurred: / /	Date when injury is evident: / /	
Person injured: <input type="checkbox"/> Athlete <input type="checkbox"/> Coach <input type="checkbox"/> Other:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	
Supervising coach: _____ (Signature)	Witness: _____ (Signature)	
First aid provided by: _____ (Signature)	Time of aid: : first	Initial treatment: <input type="checkbox"/> No treatment required <input type="checkbox"/> CPR <input type="checkbox"/> RICER <input type="checkbox"/> Crutches <input type="checkbox"/> Sling/splint <input type="checkbox"/> Dressing <input type="checkbox"/> Strapping <input type="checkbox"/> Massage <input type="checkbox"/> Stretching
Nature of injury: <input type="checkbox"/> New injury <input type="checkbox"/> Recurrent injury	<input type="checkbox"/> Aggravated injury <input type="checkbox"/> Other:	
Did the injury occur during... <input type="checkbox"/> Training <input type="checkbox"/> Event <input type="checkbox"/> Other:		
Symptoms of injury: <input type="checkbox"/> Blisters <input type="checkbox"/> Inflammation/swelling <input type="checkbox"/> Spinal injury <input type="checkbox"/> Bleeding nose <input type="checkbox"/> Cramp <input type="checkbox"/> Cardiac problem <input type="checkbox"/> Bruising/contusion <input type="checkbox"/> Suspected bone fracture/break <input type="checkbox"/> Electrical shock <input type="checkbox"/> Cut <input type="checkbox"/> Dislocation <input type="checkbox"/> Burn <input type="checkbox"/> Graze/abrasion <input type="checkbox"/> Concussion/head injury <input type="checkbox"/> Insect bite/sting <input type="checkbox"/> Sprain <input type="checkbox"/> Loss of consciousness <input type="checkbox"/> Poisoning <input type="checkbox"/> Strain <input type="checkbox"/> Respiratory problem <input type="checkbox"/> Other:		
Body part injured:	How did the injury occur?	
	<input type="checkbox"/> Collision with a fixed object <input type="checkbox"/> Overbalance	
	<input type="checkbox"/> Collision/contact with another <input type="checkbox"/> Overstretch person	
	<input type="checkbox"/> Fall from height/awkward landing <input type="checkbox"/> Slip/trip	
	<input type="checkbox"/> Fall/stumble on same level <input type="checkbox"/> Other:	
	Extra detail regarding how the injury occurred:	
Was protective equipment worn on the injured body part? <input type="checkbox"/> Yes <input type="checkbox"/> No		
action:	<input type="checkbox"/> None <input type="checkbox"/> Medical practitioner/physiotherapist <input type="checkbox"/> Hospital Follow up <input type="checkbox"/> Ambulance <input type="checkbox"/> Other:	

Signature of person completing form:	Date:            /        /
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**Note:** Coaches without medical training should refer all medical decisions to appropriately qualified persons. Do not attempt to 'diagnose' an injury. Users of this form are advised that medical information should be treated confidentially. In some states, additional legislation affects the management of health records. See [www.austlii.edu.au](http://www.austlii.edu.au) for further information.