



SPECIAL OLYMPICS

FIRST REPORT OF ACCIDENT / INCIDENT



U.S. PROGRAM/AREA: _____ **Date of Incident:** _____

Injured Person/Party Information Date of Birth: ____/____/____ Age: _____

Name: _____
 (Last) (First) (MI)

Address: _____
 (Street) (City) (State) (Zip)

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____

Gender: Male Female Social Security Number: _____ - _____ - _____

- INJURED PARTY:**
- Athlete
 - Volunteer
 - Coach
 - Employee
 - Spectator
 - Unified Partner
 - Property Owner
 - Other: _____

- TYPE OF INJURY/ ACCIDENT:**
- Bodily Injury
 - Property Damage
 - Automobile
 - Other: _____

Description of Accident (If automobile accident occurred, please attach a copy of the police report).

Describe how the accident occurred (Attach a separate sheet if necessary): _____

Site / event where accident occurred: _____

| | | | |
|--|---|---|--|
| <p>ACCIDENT OCCURRED DURING:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Training/Practice <input type="checkbox"/> Competition <input type="checkbox"/> Traveling to or from SO event <input type="checkbox"/> Other: _____ <p>TYPE OF INJURY:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Severe cut w/ bleeding <input type="checkbox"/> Less serious bruise or cut <input type="checkbox"/> Break/fracture <input type="checkbox"/> Concussion <input type="checkbox"/> Paralysis <input type="checkbox"/> Fatality <input type="checkbox"/> Other: _____ | <p>DISPOSITION:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Released to parent <input type="checkbox"/> Refusal of care <input type="checkbox"/> Refer to doctor <input type="checkbox"/> Refer to hospital or clinic <input type="checkbox"/> Medical attention <input type="checkbox"/> EMS transport <input type="checkbox"/> Patient requested EMS transport <input type="checkbox"/> Released to personal vehicle <input type="checkbox"/> Police <input type="checkbox"/> Ambulance <input type="checkbox"/> Report only <input type="checkbox"/> Other: _____ | <p style="text-align: center;">SPORT</p> <ul style="list-style-type: none"> <input type="checkbox"/> Alpine Skiing <input type="checkbox"/> Aquatics <input type="checkbox"/> Athletics <input type="checkbox"/> Badminton <input type="checkbox"/> Baseball <input type="checkbox"/> Basketball <input type="checkbox"/> Bocce <input type="checkbox"/> Bowling <input type="checkbox"/> Cheerleading <input type="checkbox"/> Cross Country Ski <input type="checkbox"/> Cycling <input type="checkbox"/> Equestrian <input type="checkbox"/> Figure Skating <input type="checkbox"/> Floor Hockey <input type="checkbox"/> Golf <input type="checkbox"/> Gymnastics <input type="checkbox"/> Kickball <input type="checkbox"/> Power Lifting <input type="checkbox"/> Relay Game <input type="checkbox"/> Roller Skating <input type="checkbox"/> Sailing <input type="checkbox"/> Snowboarding <input type="checkbox"/> Snowshoe <input type="checkbox"/> Soccer <input type="checkbox"/> Softball <input type="checkbox"/> Speed Skating <input type="checkbox"/> Swimming <input type="checkbox"/> Table Tennis <input type="checkbox"/> Team Handball <input type="checkbox"/> Tennis <input type="checkbox"/> Track & Field <input type="checkbox"/> Volleyball <input type="checkbox"/> Other: _____ | <p>BODY PART INJURED:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Torso <input type="checkbox"/> Back <input type="checkbox"/> Hand (L / R) <input type="checkbox"/> Finger (L / R) <input type="checkbox"/> Elbow (L / R) <input type="checkbox"/> Shoulder (L / R) <input type="checkbox"/> Leg (L / R) <input type="checkbox"/> Knee (L / R) <input type="checkbox"/> Thigh (L / R) <input type="checkbox"/> Shin (L / R) <input type="checkbox"/> Toe (L / R) <input type="checkbox"/> Other: _____ |
|--|---|---|--|

Contact/Care Provider Information (If an athlete or underage volunteer was injured, please identify the care provider and/or responsible party (e.g. parent, legal guardian).

Relationship to the injured person: _____ Employer Name: _____

Name: _____ Employer Address: _____

Address: _____ Work Phone: (____) _____ - _____

Home Phone: (____) _____ - _____

Does the injured person have medical insurance? Yes No

If yes, insurance is provided by: Injured Person Care Provider/Responsible Party

Please provide name of Company and Policy Number: _____

Witness Information (Please provide names and phone numbers of any witnesses to the incident)

Witness #1 Name: _____ Daytime Phone: (____) _____ - _____

Witness #2 Name: _____ Daytime Phone: (____) _____ - _____

Special Olympics Official / Representative (other than claimant)

Name: _____ Daytime Phone: (____) _____ - _____

Signature: _____