CAMPUS RECREATION

INCIDENT REPORT FORM

Instructions: Completely fill out all areas and provided detailed information.

Individual Contact Information

Last Name:	Fist Name:	MI:	ID #:	
Address:			Home/Cell Phone:	D.O.B / /
City:	State:	Zip:	Work Phone:	Gender: ☐M ☐F ☐N

Individual Status:

☐Student Member ☐Faculty/Staff Member ☐Guest ☐Other_____

Date of Incident: / /	Time of Incident: _____ am/ pm

General Facility Location/ Venue where injury occurred:

☐BRIC

1st Floor ☐Climbing Wall ☐ Spinning Studio ☐ MMA Studio ☐ Mind/Body Studio ☐Group X Room ☐Pool

2nd Floor ☐Locker Room ☐2nd Floor Functional Training Area ☐MAC Court ☐Court 1 ☐Court 2 ☐Court 3

3rd Floor ☐Cardio Area ☐Free Weight Area ☐Track ☐Racquetball Court

☐Kellogg Stadium ☐Kellogg Gym ☐Activity Field ☐Darlene May Gym ☐Intramural Field

☐Other _____

Program (If applicable): ☐Adventures ☐Aquatics ☐Fitness ☐Intramurals ☐Other:_____

Suspected Part of Body Injured (Indicate left or right):

☐Abdomen ☐Chest ☐Face ☐Hand ☐Leg ☐Shoulder ☐Ankle ☐Ear
☐Finger ☐Head ☐Mouth ☐Tooth ☐Arm ☐Elbow ☐Foot ☐Hip
☐Nose ☐Thigh ☐Back ☐Eye ☐Forearm ☐Knee ☐Scalp ☐Wrist
☐Other:_____

☐**RIGHT**

☐**LEFT**

Aid Offered By:_____ Staff Care: ☐ Accepted ☐ Declined Medical Services: ☐ Accepted ☐ Declined	Care Provided:_____ _____ _____ _____
Presence of Blood? ☐ YES ☐ NO	Was Bleeding Stopped? ☐ YES ☐ NO

Did injured individual continue participating in activities, practice or competition? ☐ YES ☐ NO

Individual Injured Left Facility/ Venue to:	Transportation Provided:
☐Campus Health ☐Home ☐Hospital ☐Class	☐Left On Own ☐University Police ☐Refused Transportation
☐Unknown	☐Ambulance
☐Other:_____	☐Left with a Teammate/ Friend_____ (Provide Name of teammate/ friend if possible)

EMERGENCY RESPONSE

Description of Incident: *(Please describe in detail the circumstances of the incident occurring)*

_____

_____

_____

_____

_____

_____

_____

(Please attach a separate sheet if more space is required.)

STAFF PRESENT

Name: _____
Dept: _____

Name: _____
Dept: _____

Name: _____
Dept: _____

Name: _____
Dept: _____

Name: _____
Dept: _____

Name: _____
Dept: _____

NON-STAFF WITNESS(ES) CONTACT INFORMATION: (Please fill out all information completely)

Name: _____
Bronco #: _____
Address: _____
_____
Phone: _____
Email: _____

Name: _____
Bronco #: _____
Address: _____
_____
Phone #: _____
Email: _____

Individual Signature: _____ Date: __/____/____
Facility Supervisor (Print): _____
Facility Supervisor Signature: _____ Date:___/___/____

Office Use Only

Reviewed By: _____ Position: _____
(Print)

Signature: _____ Date: ____/____/_____

Follow-up (Each attempt to contact the injured individual must be listed with both date and time): _____
_____

_____

_____