



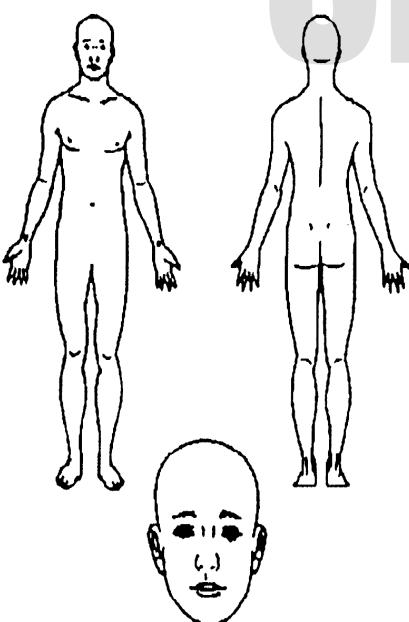
# La Pine Soccer Academy Injury Reporting Form

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Injury Location: \_\_\_\_\_ Coach: \_\_\_\_\_ Team: \_\_\_\_\_

Today's date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Time : \_\_\_\_ am/pm Gender:  Male  Female Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Injured person (please circle): Player / Referee / Coach / Spectator

<b>TYPE OF ACTIVITY AT TIME OF INJURY</b> <p><input type="checkbox"/> training <input type="checkbox"/> warm-up <input type="checkbox"/> competition <input type="checkbox"/> cool-down <input type="checkbox"/> other _____</p>	<b>CAUSE OF INJURY</b> <p><input type="checkbox"/> collision with fixed object <input type="checkbox"/> collision with another player <input type="checkbox"/> fall from height/awkward landing <input type="checkbox"/> injured ankle <input type="checkbox"/> overexertion <input type="checkbox"/> overuse <input type="checkbox"/> slip/trip/fall/stumble <input type="checkbox"/> struck by ball/object <input type="checkbox"/> struck by another player <input type="checkbox"/> temperature related <input type="checkbox"/> other _____</p>	<b>ADVICE GIVEN</b> <p><input type="checkbox"/> immediate return to activity <input type="checkbox"/> return to play with restriction  <input type="checkbox"/> unable to return at present <input type="checkbox"/> referred for further assessment before returning to activity</p>
<b>REASON FOR PRESENTATION</b> <p><input type="checkbox"/> new injury <input type="checkbox"/> aggravated injury <input type="checkbox"/> recurrent injury <input type="checkbox"/> illness <input type="checkbox"/> other _____</p>	<b>Explain how the incident occurred</b> <hr/> <hr/> <hr/> <hr/> <hr/>	<b>NOTICE</b> <p>The injured person told that if injury/illness does NOT improve in the following 24 hours they MUST seek further advice from their own medical professional.</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<b>BODY PARTS INJURED</b> <i>circle and name</i>		<b>REFERRAL</b> <p><input type="checkbox"/> no referral <input type="checkbox"/> medical practitioner <input type="checkbox"/> physiotherapist <input type="checkbox"/> ambulance <input type="checkbox"/> hospital <input type="checkbox"/> other _____</p>
<b>NATURE OF INJURY/ILLNESS</b>	<b>Were there any contributing factors to the incident? e.g. unsuitable footwear, playing surface, equipment, foul play</b>	<b>PROVISIONAL SEVERITY ASSESSMENT</b>
<input type="checkbox"/> bruise/contusion <input type="checkbox"/> cardiac problem <input type="checkbox"/> cold/flu <input type="checkbox"/> concussion <input type="checkbox"/> dislocation/subluxation <input type="checkbox"/> fracture (including suspected) <input type="checkbox"/> inflammation/swelling <input type="checkbox"/> loss of consciousness <input type="checkbox"/> overuse injury <input type="checkbox"/> respiratory problem <input type="checkbox"/> skin injury e.g. graze/cut/blisters <input type="checkbox"/> sprain e.g. ligament tear <input type="checkbox"/> strain e.g. muscle tear <input type="checkbox"/> unspecified medical condition <input type="checkbox"/> other _____	<b>Was protective equipment worn on the injured body part?</b>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, what? e.g. mouth guard, brace?</p> <hr/> <hr/> <hr/>
	<b>ACTION TAKEN</b>	<p><input type="checkbox"/> none given (not required) <input type="checkbox"/> CPR <input type="checkbox"/> dressing <input type="checkbox"/> immobilization <input type="checkbox"/> RICER (Rest, Ice, Compression, Elevation, Referral) <input type="checkbox"/> sling/splint <input type="checkbox"/> strapping/taping <input type="checkbox"/> stretch/exercises <input type="checkbox"/> transport from field/court <input type="checkbox"/> Seeking medical attention from doctor <input type="checkbox"/> other _____</p>
		<p>Signature of parent or guardian</p> <hr/> <hr/> <hr/>
		<p>Signature of treating person</p> <hr/> <hr/> <hr/>
		<p>Date: ____ / ____ / ____</p>