

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

TYPE OF ACTIVITY AT TIME OF INJURY

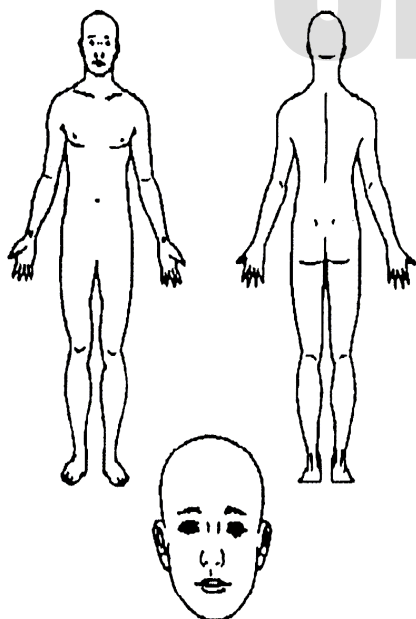
- ☐ training
- ☐ warm-up
- ☐ competition
- ☐ cool-down
- ☐ other _____

REASON FOR PRESENTATION

- ☐ new injury
- ☐ aggravated injury
- ☐ recurrent injury
- ☐ illness
- ☐ other _____

BODY PARTS INJURED

circle and name



NATURE OF INJURY/ILLNESS

- ☐ bruise/contusion
- ☐ cardiac problem
- ☐ cold/flu
- ☐ concussion
- ☐ dislocation/subluxation
- ☐ fracture (including suspected)
- ☐ inflammation/swelling
- ☐ loss of consciousness
- ☐ overuse injury
- ☐ respiratory problem
- ☐ skin injury e.g. graze/cut/blisters
- ☐ sprain e.g. ligament tear
- ☐ strain e.g. muscle tear
- ☐ unspecified medical condition
- ☐ other _____

CAUSE OF INJURY

- ☐ collision with fixed object
- ☐ collision with another player
- ☐ fall from height/awkward landing
- ☐ injured ankle
- ☐ overexertion
- ☐ overuse
- ☐ slip/trip/fall/stumble
- ☐ struck by ball/object
- ☐ struck by another player
- ☐ temperature related
- ☐ other _____

Explain how the incident occurred

Were there any contributing factors to the incident? e.g. unsuitable footwear, playing surface, equipment, foul play

Was protective equipment worn on the injured body part?

☐ Yes ☐ No

If yes, what? e.g. mouth guard, brace?

ACTION TAKEN

- ☐ none given (not required)
- ☐ CPR
- ☐ dressing
- ☐ immobilization
- ☐ RICER (Rest, Ice, Compression, Elevation, Referral)
- ☐ sling/splint
- ☐ strapping/taping
- ☐ stretch/exercises
- ☐ transport from field/court
- ☐ Seeking medical attention from doctor
- ☐ other _____

ADVICE GIVEN

- ☐ immediate return to activity
- ☐ return to play with restriction

☐ unable to return at present
☐ referred for further assessment before returning to activity

NOTICE

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.

☐ Yes ☐ No

REFERRAL

- ☐ no referral
- ☐ medical practitioner
- ☐ physiotherapist
- ☐ ambulance
- ☐ hospital
- ☐ other _____

PROVISIONAL SEVERITY ASSESSMENT

- ☐ mild (1 - 7 days modified activity)
- ☐ moderate (8-21 days modified activity)
- ☐ severe (>21 days modified or lost)

TREATING PERSON

- ☐ Sports Trainer/Sports First Aider (ID _____)
- ☐ medical practitioner
- ☐ physiotherapist
- ☐ other _____

Signature of parent or guardian

Signature of treating person

Date: ____/____/____