CY-FAIR SPORTS ASSOCIATION

VOLLEYBALL FIRST REPORT OF ACCIDENT

(This form is to be completed by a coach or manger. In the event that more than 1 person is injured, a separate report will be completed for each injured party. The completed form will be forwarded to volleyball@cy-fairsports.org or fax to 281-970-8099.)

INCIDENT DATE: _____ INCIDENT TIME: _____AM / PM WHICH COMPLEX: _____

TYPE OF SPORT: _____ TEAM NAME: _____ LEAGUE: _____

HOW THE INCIDENT OCCURRED: _____

_____

BODY PART INJURED: _____

INJURED PERSON (CIRCLE): ATHLETE OFFICIAL COACH SPECTATOR EMPLOYEE VOLUNTEER OTHER _____

WHERE AT THE COMPLEX DID THE INJURY OCCUR: _____?

CLASSIFICATION OF INJURY (CIRCLE): NON-INJURY MINOR INJURY/ILLNESS SERIOUS INJURY/ILLNESS

DISPOSITION: ( ) RELEASED TO PARENT ( ) REFUSAL OF CARE ( ) REFER TO DOCTOR

( ) REFER TO HOSPITAL OR CLINIC ( ) MEDICAL ATTENTION ( ) EMS TRANSPORT

( ) PATIENT REQUESTED EMS ( ) RELEASED TO PERSONAL VEHICLE

If transported to medical facility, please provide name and location: _____

_____

INJURED PERSON INFORMATION:

Last Name _____First _____ MI ___

Address _____ SS# _____

City _____ _____ State _____ Zip _____

Age _____ D.O.B. _____ Tel.# _____ Male / Female

GUARDIAN/PARENT (IF INJURED PERSON IS A MINOR)

Last Name _____First _____ MI_____

Address _____ Tel.# _____

City _____ State _____ Zip _____

INSURANCE INFORMATION: (IF INJURED HAS INSURANCE, PLEASE PROVIDE NAME BELOW)

Insurance Company Name: _____

WITNESSES:

NAME _____ TEL.# _____

NAME _____ TEL.# _____

Signature of Coach or Manager: _____ Date _____