



CY - FAIR SPORTS ASSOCIATION

WRESTLING 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 wrestling@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 _____