

# INCIDENT / INJURY REPORT FORM

This form should be filled out and submitted when a serious incident or injury occurs that requires professional medical attention (i.e. a call to 911, a trip to the doctor and/or hospital). In the event of an incident involving critical injury or death, please call the League Director at (206) 291-7773 to report immediately.

## RETURN TO:

Washington Student Cycling League  
P.O. Box 22187  
Seattle, WA 98122  
E info@washingtonleague.org  
T 206-291-7773 | F 206-577-4564  
W www.washingtonleague.org

Please submit this form to the League Director within 24 hours of the incident.

Date of Incident: _____ Time of Incident: _____ CHECK ONE: <input type="checkbox"/> Personal Injury <input type="checkbox"/> Property Damage	Person in charge at the time of the incident: Name: _____ Phone: _____
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<b>INJURED PERSON INFORMATION</b> <input type="checkbox"/> Student-Athlete <input type="checkbox"/> Coach <input type="checkbox"/> Guest/Spectator <input type="checkbox"/> Other: _____
Name of Injured Person: _____ <input type="checkbox"/> Male <input type="checkbox"/> Female DOB: _____
Address: _____ City/State/Zip: _____
Phone: _____ Email Address: _____
Team Name: _____ Was the injured person wearing a helmet at the time of the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No

<b>INCIDENT DETAILS</b>		
Activity Type: <input type="checkbox"/> Team Practice/Ride <input type="checkbox"/> Race <input type="checkbox"/> Other (specify): _____		
Where did the incident occur: <input type="checkbox"/> On Trail (specify): _____ <input type="checkbox"/> On Road (specify): _____ <input type="checkbox"/> At School (specify): _____ <input type="checkbox"/> Other (specify): _____		
Phase of activity/event incident occurred: <input type="checkbox"/> Before <input type="checkbox"/> During <input type="checkbox"/> After		
Phase of ride when incident occurred: <input type="checkbox"/> Beginning <input type="checkbox"/> Middle <input type="checkbox"/> End		
Approximate distance from trailhead at time of incident: _____		
Describe the incident. How did the incident occur? (Use back if necessary): _____ _____ _____		
<b>WEATHER CONDITIONS</b> <input type="checkbox"/> Sunny <input type="checkbox"/> Raining <input type="checkbox"/> Foggy <input type="checkbox"/> Snowy <input type="checkbox"/> Cloudy <input type="checkbox"/> Extreme Temp	<b>TRAIL/ROAD CONDITIONS</b> <input type="checkbox"/> Wet <input type="checkbox"/> Dry <input type="checkbox"/> Icy <input type="checkbox"/> Other: _____	<b>TRAIL/ROAD TYPE</b> <input type="checkbox"/> Paved <input type="checkbox"/> Dirt <input type="checkbox"/> Gravel <input type="checkbox"/> Off-Road/Trail
How many were present at the time of the incident: Student-Athletes: _____ Adults: _____		

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<b>CLASSIFICATION OF INJURY</b>  <input type="checkbox"/> Non-Injury <input type="checkbox"/> Minor injury or illness <input type="checkbox"/> Serious injury or illness	<b>BODY PART INJURED</b>			
	<input type="checkbox"/> Eye:   __Right __Left	<input type="checkbox"/> Wrist:   __Right __Left	<input type="checkbox"/> Head	<input type="checkbox"/> Internal
	<input type="checkbox"/> Ankle:   __Right __Left	<input type="checkbox"/> Shoulder:   __Right __Left	<input type="checkbox"/> Face	<input type="checkbox"/> Back
	<input type="checkbox"/> Knee:   __Right __Left	<input type="checkbox"/> Foot:   __Right __Left	<input type="checkbox"/> Ear	<input type="checkbox"/> Nose
	<input type="checkbox"/> Hand:   __Right __Left	<input type="checkbox"/> Leg:   __Right __Left	<input type="checkbox"/> Mouth	<input type="checkbox"/> Tooth
<input type="checkbox"/> Arm:   __Right __Left	<input type="checkbox"/> Elbow   __Right __Left	<input type="checkbox"/> Neck	<input type="checkbox"/> Finger(s)	
<input type="checkbox"/> Hip:   __Right __Left	<input type="checkbox"/> Ear   __Right __Left	<input type="checkbox"/> Torso	<input type="checkbox"/> Toe(s)	

<b>PRIMARY INJURY</b>				
<input type="checkbox"/> Allergy	<input type="checkbox"/> Concussion	<input type="checkbox"/> Heat Exhaustion	<input type="checkbox"/> Abrasion	<input type="checkbox"/> Cold Injury
<input type="checkbox"/> Fracture	<input type="checkbox"/> Nausea	<input type="checkbox"/> Tooth/Mouth	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Burn
<input type="checkbox"/> Seizure	<input type="checkbox"/> Drowning	<input type="checkbox"/> Electrical Shock	<input type="checkbox"/> Foreign Body	<input type="checkbox"/> Laceration
<input type="checkbox"/> Dislocation	<input type="checkbox"/> Strain/Sprain	<input type="checkbox"/> Pain	<input type="checkbox"/> Cardiac	<input type="checkbox"/> Confusion
<input type="checkbox"/> Death	<input type="checkbox"/> Amputation	<input type="checkbox"/> Stroke	<input type="checkbox"/> Illness	<input type="checkbox"/> Sting/Bite

<b>TREATMENT</b>				
On-Site Care Given by:	<input type="checkbox"/> Coach	<input type="checkbox"/> Parent	<input type="checkbox"/> Other Adult	<input type="checkbox"/> EMT/Paramedic
	<input type="checkbox"/> League Staff/Volunteer			
	<input type="checkbox"/> Other (specify): _____			
Name of Person Who Gave Care:	_____			Level of Training: _____
Care Given on Site:	<input type="checkbox"/> Ice	<input type="checkbox"/> Immobilization	<input type="checkbox"/> Bandage	<input type="checkbox"/> Cleaned
	<input type="checkbox"/> CPR			
	<input type="checkbox"/> Other (specify): _____			
Emergency Contact Notified:	<input type="checkbox"/> Yes	<input type="checkbox"/> No		

<b>DISPOSITION</b>		
<input type="checkbox"/> Report Only	<input type="checkbox"/> Refer to Doctor	<input type="checkbox"/> Continued Riding
<input type="checkbox"/> Released to Parent	<input type="checkbox"/> Refer to Hospital/Clinic	<input type="checkbox"/> injured requested EMS Transport
<input type="checkbox"/> Police	<input type="checkbox"/> Medical Attention	<input type="checkbox"/> Released to personal vehicle
<input type="checkbox"/> Ambulance	<input type="checkbox"/> EMS Transport	<input type="checkbox"/> <b>REFUSAL OF CARE</b>

<b>WITNESSES</b>	
Please include the names and phone number of two (2) witnesses:	
Name: _____	Phone: _____
Name: _____	Phone: _____

<b>SUBMITTED BY</b>	
I prepared this report and attest that the foregoing information is true and correct to the best of my knowledge.	
Printed Name: _____	Signature: _____
Date: _____	Phone: _____

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Please use this area to for any additional information.