

INCIDENT / INJURY REPORT FORM



This form should be filled out and submitted when an accident or injury occurs during a WSCL team practice, race, coaches training or camp that results in physical harm to the participant significant enough to:

- Warrant referral to a medical provider or visit to a medical facility, or
- Participant misses school, work, or time from training/competition beyond day of injury, or
- Any helmet damage or potential brain injury (including concussion), or
- Any fractures, broken bones or lacerations requiring stitches.

As an organization, we are committed to promoting the health and wellness of every student-rider while they train and race. Washington Student Cycling League is implementing a new injury-tracking system to better understand what injuries our student-riders sustain.

Please select all applicable injury triggers that have led to this report. *

- Referral was made to a medical provider or visit to a medical facility.
 Participant has missed school, work, or time from training/competition beyond day of injury.
 There was helmet damage and/or potential brain injury (including concussion).
 There was a fracture, broken bone or lacerations requiring stitches.

INJURED PERSON INFORMATION

Name of Injured Person: * _____

Injured Person is: * Student-Rider Coach / Team Volunteer Other

Date of Birth: _____

Check One: * Female Male Other or prefer not to identify

Address * _____

City: _____ State _____ Zip: _____

Team Name: * _____

League Division * High School Middle School

PRIMARY CONTACT INFORMATION

The primary contact is the parent or legal guardian of the injured person if s/he is a minor, or the injured person if s/he is an adult.

Primary Contact 1

Name of Primary Contact: * _____

Phone Number * _____ Email * _____

Primary Contact 2

Name of Primary Contact: * _____

Phone Number * _____ Email * _____

INCIDENT DETAILS

Date and Time of Incident: * _____

Activity Type: *

_____ Team Practice/Ride - parking lot or meet area

_____ Team Practice/Ride - skills training
_____ Race

_____ Team Practice/Ride - on trail

_____ Class/Clinic Camp

Where did the incident occur, please be specific: *

	Specify Name & Location
On Trail	
On Road	
At School	
Other	

Phase of activity/event incident occurred: * _____ Before _____ During _____ After

At which point in ride did the injury occur? *

_____ N/A (did not happen on the bike)

_____ End of ride/race

_____ Warm-Up First 1/3 of ride or race

_____ Finish Line Cool-Down

_____ Middle 1/3 of ride or race

_____ Other

Weather Conditions: *

_____ Sunny _____ Raining. _____ Foggy _____ Snowy. _____ Cloudy. _____ Extreme Temp

Trail/Road Conditions: *

Wet Dry Icy

Trail/Road Type: *

Paved Dirt Gravel Off-Road Trail

Please provide a description of how the incident occurred, along with any factors that may have contributed to the incident. If you have any input on how to reduce the likelihood of any similar incidents, please let us know. *

Was the venue or route familiar to the injured rider? *

- N/A
- No, the rider has not ridden on this trail before
- Yes, the rider has ridden on this trail before
- Unsure

Were any of the following associated with the injury? Check all that apply. *

- Weather
- Occurred on a turn
- Passing another rider or getting passed
- Mechanical problem (i.e. failing brakes, loose cables, etc.)
- Highly technical nature of the portion of the trail (i.e. obstacle, difficult turn, loose terrain, etc.)
- Inexperience of the student-rider (i.e. a more experienced rider would not have made the same mistake) Nothing

What was the trail incline where the injury occurred? *

- N/A - didn't happen on a trail
- Downhill / Descending
- Flat
- Uphill / Ascending

INJURY AND CARE GIVEN

Body Part Injured. Check all that apply.

	Eye	Ear	Shoulder	Collar Bone	Arm	Elbow	Wrist	Hand	Hip	Knee	Leg	Ankle	Foot
Left													
Right													

Body Part Injured - Continued.

- | | | |
|--------------------------------|---|------------------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> Teeth | <input type="checkbox"/> Abdomen |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Torso | <input type="checkbox"/> Finger(s) |
| <input type="checkbox"/> Face | <input type="checkbox"/> Upper Back/Spine | <input type="checkbox"/> Toe(s) |
| <input type="checkbox"/> Nose | <input type="checkbox"/> Lower Back/Spine | <input type="checkbox"/> Internal |
| <input type="checkbox"/> Mouth | <input type="checkbox"/> Chest | |

Symptoms / Possible Injury:

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

On-Site Treatment Given By: *

- | | | |
|--|---|--|
| <input type="checkbox"/> None Provided | <input type="checkbox"/> Other Adult | <input type="checkbox"/> EMT/Paramedic |
| <input type="checkbox"/> Coach | <input type="checkbox"/> PERSON REFUSED | <input type="checkbox"/> League Staff |
| <input type="checkbox"/> Parent | CARE | |

Name of Person Who Gave Care: _____

Description of On-Site Treatment:

Was the injured person able to complete the session or race? *

N/A Yes No

Was the injured person evacuated from the trail or race course by emergency personnel? Note: WSCL coaches and volunteers are NOT considered emergency personnel. *

Yes No Unknown

Did the injured person go to the emergency room at any time for the injury? *

No Went to ER, sent home Went to ER, admitted to hospital Unknown

Was the injured person transported to the emergency room by ambulance? *

No Yes

Please provide a description or diagnosis of the injury: *

Was this definitely a season-ending injury for the person? *

Yes No Not Sure

Was Emergency Contact Notified? *

Yes No

RESPONSIBLE PARTY

Who was leading the ride, or running the event? * _____

Did the ride or event leader (person noted in previous question) witness the injury event? *

Yes No Unsure. N/A

[LEAGUE ONLY] What is the licensing level of the coach who in charge of the ride?

Level 1 Level 2. Level 3

WITNESSES

Name of Witness to Injury: _____

Phone Number of Witness: _____

Name of Witness to Injury: _____

Phone Number of Witness: _____

REPORTING PARTY

Person Submitting Report: * _____

Phone Number: * _____

Email * _____