

ACA Incident/Accident Report Form

If additional space is needed please attach separate piece of paper

DATE OF INCIDENT _____ TIME OF INCIDENT _____ AM/PM Name of Club: _____ Address: _____ Telephone Number: _____	DOES THE INJURED PERSON HAVE OTHER MEDICAL INSURANCE? YES NO If yes, please provide name of company and policy #: _____
INJURED PERSON: Participant/Athlete Official Coach Spectator Employee Volunteer Other _____ Was injured person a member of organization? Yes No	DID THIS TAKE PLACE DURING (check all that apply): Practice Competition Club Activity/Event Pre-activity Sanctioned Activity/Event After activity While traveling

INJURED PERSON INFORMATION					
Last Name	First	Middle	Telephone Number ()	Single	Married
Address			Social Security Number _____		
City	State	Zip	Employer and Address		
Age	D.O.B.	Male Female			

GUARDIAN/PARENT (IF INJURED PERSON IS A MINOR)					
Last Name	First	Middle	Telephone Number ()		
Address			City	State	Zip

SUSPECTED PRE-EXISTING CONDITION: Yes No

<p style="text-align: center;">INCIDENT LOCATION</p> Competition area Concession area Parking lot Admission area Restrooms/locker rooms Off property Premises/grounds Store area Bleachers/stands <p style="text-align: center;">CLASSIFICATION</p> Facility or event related Non-injury Not facility or event related Minor injury or illness Serious injury or illness	<p style="text-align: center;">INCIDENT</p> Assault/Sexual Slip, bodily reaction Assault/Non-Sexual Slip/Fall Fall (different level) Eligibility Fall (same level) Aquatic Caught in, on, between Trip/Fall Animal/insect bite/sting Drug Testing Collision (with object) Overexertion Collision (participant/participant) Collision (participant/spectator) Collision (spectator/spectator) Struck by falling/flying object <input type="checkbox"/> Auto/Property	<p style="text-align: center;">MEDICAL SERVICES</p> Antacid Eye rinse Aspirin Glucose Aspirin substitute Ice Pack Bandaged Oxygen Ointment/antiseptic Rest Removal Splinted CPR Wrapped Cleansed Exam Cold Pack None Treated by _____
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<p style="text-align: center;">PRIMARY INJURY</p> Allergy Dislocation Nausea Amputation Electrical Shock Stroke Abrasion Foreign Body Burn Laceration Fracture Death Drowning Heat Exhaustion Pain Hypertension Cardiac Illness Cold Injury Contusion Sting/bite Seizures Concussion Strain/Sprain Tooth/Mouth	<p style="text-align: center;">BODY PART INJURED</p> Eye (L/R) Torso Arm (L/R) Nose Back Tooth Neck Face Head Ear (L/R) Leg (L/R) Knee (L/R) Ankle (L/R) Internal Hip (L/R) Shoulder (L/R) Foot (L/R) Elbow (L/R) Hand (L/R) Wrist (L/R) Finger or Toe	<p style="text-align: center;">DISPOSITION</p> Released to parent Police Refusal of care Ambulance Refer to doctor Report only Refer to hospital or clinic Medical attention EMS transport Patient requested EMS transport Released to personal vehicle
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Describe how the incident occurred:

WITNESS INFORMATION

NAME	ADDRESS	TELEPHONE NUMBER
1.		()
2.		()

Signature of Official (with no relationship to claimant) _____ DATE _____

Phone # _____

Send Completed Report to:

ACA

Attn: Recreation Outreach
7432 Alban Station Blvd., B-232
Springfield, VA 22150
Phone: (703) 451-0141
Fax: (703) 451-2245