

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? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please provide name of company and policy #: _____
INJURED PERSON: <input type="checkbox"/> Participant/Athlete <input type="checkbox"/> Official <input type="checkbox"/> Coach <input type="checkbox"/> Spectator <input type="checkbox"/> Employee <input type="checkbox"/> Volunteer <input type="checkbox"/> Other _____ Was injured person a member of organization? <input type="checkbox"/> Yes <input type="checkbox"/> No	DID THIS TAKE PLACE DURING (check all that apply): <input type="checkbox"/> Practice <input type="checkbox"/> Competition <input type="checkbox"/> Club Activity/Event <input type="checkbox"/> Pre-activity <input type="checkbox"/> Sanctioned Activity/Event <input type="checkbox"/> After activity <input type="checkbox"/> While traveling

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

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
1340 Central Park Blvd., Suite 210
Fredericksburg, VA 22401
Phone: (540) 907-4460
Fax: (888) 229-3792