|  |
| --- |
| Injury Details: *This report reflects an accurate record of the patients reported symptoms of injury* |
| **Name of person injured:** | DOB:(Day/Month/Year) |  / / |
| **Date when injury occurred:** / / | Date when injury is evident: |  / / |
| **Person injured:** □ Athlete □ Coach □ Other: | **Gender:** □ M □ F |
| **Supervising Coach:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (Name & Signature)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Witness:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (Name & Signature)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| First Aid provided by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Name & Signature)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date of**First Aid:** |  / / | **Initial Treatment:**  |
| □ No treatment required |
| Reason for presentation: | * New Injury
 | Aggravated Injury | □ CPR | □ RICER  |
| * Recurrent Injury
 | * Other:
 | □ Crutches | □ Sling/splint |
| Where did the injury occur? | □ Dressing | □ Strapping |
| □ Training | □ Event | □ Other: | □ Massage | □ Stretches |
| Symptoms of Injury: |
| * Blisters
 | * Electrical Shock
 | * Pain
 |
| * Blood Nose
 | * Fracture/Break *(inc. suspected)*
 | * Poisoning
 |
| * Bruising/Contusion
 | * Graze/Abrasion
 | * Respiratory Problem
 |
| * Burn
 | * Heavy bleeding
 | * Spinal
 |
| * Cardiac problem
 | * Inflammation /Swelling
 | * Sprain
 |
| * Concussion
 | * Infection
 | * Strain
 |
| * Cut/Laceration
 | * Insect Bite/Sting
 | * Tenderness
 |
| * Discoloration
 | * Loss of consciousness
 | * Other
 |
| * Dislocation
 | * Open wound/laceration
 | * Other
 |
| **Body part injured:** | How did the injury occur? |
|  | * Collision with fixed object e.g. vaulting horse
 | * Overbalance
 |
| * Collision with another person
 | * Overstretch
 |
| * Fall from height/awkward landing
 | * Slip/trip
 |
| * Fall /stumble on same level e.g. mats
 | * Other:
 |
| **Explain how the injury occurred (ie: sequence of events):** |
| **Was protective equipment worn on the injured site?**e.g. hand guard, footwear | □ Yes □ No |
|  | □ No referral  | □ Medical Practitioner/Physiotherapist | □ Hospital |
| □ Ambulance | □ Other: |
| **Signature of person completing form:** | **Date:** | / / |