



SPECIAL OLYMPICS

FIRST REPORT OF ACCIDENT / INCIDENT



U.S. Program/Area: Date of Incident: _____

Injured Person/Party Information Date of Birth: ____/____/____ Age: _____

Name: _____
(Last) (First) (MI)

Address: _____
(Street) (City) (State) (Zip)

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____

Gender: Male Female Social Security Number: _____ - _____ - _____

Type of Injury/ Accident:

- Bodily Injury
- Property Damage
- Automobile
- Other: _____

Injured Party:

- Athlete
- Volunteer
- Coach
- Employee
- Spectator
- Unified Partner
- Property Owner
- Other: _____

Description of Accident (If automobile accident occurred, please attach a copy of the police report).

Describe how the accident occurred (Attach a separate sheet if necessary): _____

Site / event where accident occurred: _____

- Sport**
- Alpine Skiing
 - Aquatics
 - Athletics
 - Badminton
 - Baseball
 - Basketball
 - Bocce
 - Bowling
 - Cheerleading
 - Cross Country Ski
 - Cycling
 - Equestrian
 - Figure Skating
 - Floor Hockey
 - Golf
 - Gymnastics
 - Kickball
 - Power Lifting
 - Relay Game
 - Roller Skating
 - Sailing
 - Snowboarding
 - Snowshoe
 - Soccer
 - Softball
 - Speed Skating
 - Swimming
 - Table Tennis
 - Team Handball
 - Tennis
 - Track & Field
 - Volleyball
 - Other: _____
- Body Part Injured:**
- Head
 - Neck
 - Torso
 - Back
 - Hand (L / R)
 - Finger (L / R)
 - Elbow (L / R)
 - Shoulder (L / R)
 - Leg (L / R)
 - Knee (L / R)
 - Thigh (L / R)
 - Shin (L / R)
 - Toe (L / R)
 - Other: _____

- Accident Occurred During:**
- Training/Practice
 - Competition
 - Traveling to or from SO event
 - Other: _____

- Type of Injury:**
- Severe cut w/ bleeding
 - Less serious bruise or cut
 - Break/fracture
 - Concussion
 - Paralysis
 - Fatality
 - Other: _____
- Disposition:**
- Released to parent
 - Refusal of care
 - Refer to doctor
 - Refer to hospital or clinic
 - Medical attention
 - EMS transport
 - Patient requested EMS transport
 - Released to personal vehicle
 - Police
 - Ambulance
 - Report only
 - Other: _____

Contact/Care Provider Information If an athlete or underage volunteer was injured, please identify the care provider and/or responsible party (e.g. parent, legal guardian).

Relationship to the injured person: _____ Employer Name: _____
 Name: _____ Employer Address: _____
 Address: _____ Work Phone: (____) _____ - _____

Home Phone: (____) _____ - _____
 Does the injured person have medical insurance? Yes No
 If yes, insurance is provided by: Injured Person Care Provider/Responsible Party
 Please provide name of Company and Policy Number: _____

Witness Information (Please provide names and phone numbers of any witnesses to the incident)

Witness #1 Name: _____ Daytime Phone: (____) _____ - _____
 Witness #2 Name: _____ Daytime Phone: (____) _____ - _____

Special Olympics Official / Representative (other than claimant)

Name: _____ Daytime Phone: (____) _____ - _____
 Signature: _____