DISABLED SPORTS USA INCIDENT REPORT FORM

Please submit a signed waiver & registration form for injured person, along with this form, within 24 hours of incident

Two page form must be completed by official chapter representative – please print legibly

Date of Incident: | Time of Incident:

Chapter Name:

INJURED PERSON INFORMATION

First Name: | Middle Initial: | Last Name:

Phone Number: | Date of Birth: | Age:

Gender: ❑ Male ❑ Female ❑ Prefer not to answer ❑ Other: ______________________________

Address: | City: | State: | Zip:

Disability: ❑ N/A

Injured Person: ❑ Participant ❑ Employee ❑ Volunteer ❑ Other: ______________________________

PARENT/LEGAL GUARDIAN (IF INJURED PERSON IS A MINOR OR LEGALLY INCAPACITATED)

First Name: | Last Name: | Phone Number:

Address: | City: | State: | Zip:

INJURY INFORMATION

PRIMARY INJURY RESULTING FROM INCIDENT:

❑ Abrasion
❑ Allergy
❑ Amputation
❑ Burn
❑ Cardiac
❑ Cold Injury
❑ Concussion
❑ Contusion
❑ Dislocation
❑ Foreign Body
❑ Fracture
❑ Heat Exhaustion
❑ Hypertension
❑ Hypothermia
❑ Laceration
❑ Illness
❑ Nausea
❑ Pain
❑ Seizures
❑ Sting/Bite
❑ Strain/Sprain
❑ Stroke
❑ Tooth/Mouth
❑ Other: ________________

BODY PART INJURED:

❑ Ankle (L / R)
❑ Arm (L / R)
❑ Back
❑ Ear (L / R)
❑ Elbow (L / R)
❑ Eye (L / R)
❑ Face
❑ Finger
❑ Foot (L / R)
❑ Hand (L / R)
❑ Head
❑ Hip
❑ Internal
❑ Knee (L / R)
❑ Leg (L / R)
❑ Neck
❑ Nose
❑ Shoulder (L / R)
❑ Toe
❑ Tooth
❑ Torso
❑ Wrist (L / R)
❑ Other: __________________________

INCIDENT INFORMATION

PRIMARY CAUSE OF INCIDENT:

❑ Animal bite/sting
❑ Aquatic
❑ Assault/sexual
❑ Assault/non-sexual
❑ Caught in, on, between
❑ Collision with object
❑ Collision with person
❑ Fall/Slip
❑ Fall from height
❑ Struck by falling /flying object
❑ Other: ______________________________
____

INCIDENT LOCATION: ❑ Activity Site ❑ Administrative Premises/Grounds ❑ Off Property ❑ Other: ______________________

INCIDENT TOOK PLACE DURING:

❑ Lesson ❑ Competition ❑ Training ❑ Guiding ❑ Other: ____

WEATHER CONDITIONS: ❑ Clear ❑ Icy ❑ Fog ❑ Rain ❑ Snow ❑ N/A ❑ Other: ______________________________

INCIDENT TOOK PLACE DURING WHAT SPORT/ACTIVITY:

EQUIPMENT INVOLVED IN INCIDENT:

PLEASE COMPLETE 2ND PAGE

The completed incident report is an internal document to be shared with DSUSA and our insurer only.

Revised 9/2019

Report and waiver must be submitted within 24 hours of incident to:
Willis Towers Watson at jordanj@willistowerswatson.com.

DISABLED SPORTS USA INCIDENT REPORT FORM

DISABLED SPORTS USA

DESCRIPTION OF INCIDENT

Please be as descriptive as possible and include all relevant information, including: Who was involved (please provide names and roles)? Where were they? What happened? What was the sequence of events? *Attach a separate sheet if necessary.*

RESPONSE TO INCIDENT

Please list any first aid or medical treatment provided at the time of incident? ❑ Refused Treatment

WHAT AID OR TREATMENT WAS PROVIDED?	WHO PROVIDED THE TREATMENT?	WHERE WAS AID OR TREATMENT PROVIDED?

PLEASE CHECK ALL THAT APPLY:

- ❑ Transported by ambulance to hospital
- ❑ Transported by air ambulance to hospital
- ❑ Transported by ambulance to hospital at the request of patient/parent/guardian
- ❑ Self-transported to hospital or clinic
- ❑ Referred to doctor
- ❑ Referred to hospital or clinic
- ❑ Released to parent/guardian
- ❑ Released to self
- ❑ Ski patrol assisted
- ❑ Police involved
- ❑ Other:_____________________________
____

If individual is a minor or legally incapacitated, was the parent/legal guardian notified? ❑ Yes ❑ No *If yes, when?*

Any additional information?

WITNESS INFORMATION

NAME	ROLE	ADDRESS	ZIP CODE	PHONE NUMBER

REPORTER'S INFORMATION

Name:	Position:	Date:
Address:	Phone Number:	

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