

ACCIDENT/INCIDENT REPORT FORM

10/99 Fill out 1 form for each incident or person and submit within 48 hours of the incident.

Site Name _____ Date _____

Address _____
Number & Street City State Zip

Name of Person Involved _____ Age _____ Sex _____ Camper Staff Volunteer
Last First Middle

Address _____ Phone _____
Number & Street City State Zip Area/Number

Name of Parent/Guardian (if minor) _____

Address _____ Phone _____
Number & Street City State Zip Area/Number

E-mail: _____

Name/Addresses of Witnesses (When relevant, attach signed statement.)

1. _____
2. _____
3. _____

Type of incident Behavior Accident Abuse Disclosure Chronic Illness Epidemic Illness Other (describe)

Date of Incident/Accident _____ Hour _____ a.m. p.m.

Day of the Week _____ Month _____ Day _____ Year _____

Describe the sequence of activity in detail including what the (injured) person was doing at the time.

Where occurred (Specify location, including location of injured and witnesses. Use a diagram to locate persons/objects.)

Was injured participating in an activity at the time of injury? Yes No If yes, what activity?

Was equipment involved in accident? Yes No If yes, what kind? _____

What could have been done to prevent the incident/accident? _____

By Whom? _____

Submitted by _____ Position _____ Phone _____ Date _____

MEDICAL REPORT OF ACCIDENT

Submit within 48 hours of the accident

Person notified at the council office: _____

Were parents notified? Yes No By Phone Other _____

By Whom? _____ Title _____ When _____

Parent's Response _____

Where was treatment given? at accident site doctor's office medical center hospital

If treatment was given at the event/site, where? _____

By Whom? _____ Title _____ Date _____

Treatment given _____

Was injured retained overnight in camp health service? Yes No If yes, when? _____

Treatment given _____

By Whom? _____ Title _____ Date _____

Date released from health service _____

Released to Camp Activities Home Other _____

Treatment given elsewhere than camp? Yes No Where? _____

By Whom? _____ Title _____ Date _____

Was injured retained overnight in hospital? Yes No If yes, which? _____

Where? _____ Date _____ Out-patient In-patient

Name of attending physician _____ Date released from hospital _____

Released to Home Camp Council Other _____

Comments/directions _____

Persons notified such as Camp Director/Council Staff, etc.

Name	Position	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe any contact made with/by the media regarding this situation _____

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SIGNED POSITION DATE

Insurance Notification: 1. Parents By Parent Council Date
2. Council GSUSA or Council liability
3. Worker's Compensation