ACA Incident / Accident Report Form

If additional space is needed, please attach a 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? ☐ YES ☐ NO
If yes, please provide name of company and policy #:_____
_____

INJURED PERSON: ☐ Athlete ☐ Official ☐ Coach ☐ Spectator ☐ Employee ☐ Volunteer ☐ Other _____

Was injured person a member of organization? ☐Yes ☐No

DID THIS TAKE PLACE DURING:
☐ Practice ☐ Competition ☐ Club Activity/Event
☐ Pre-activity ☐ Sanctioned Activity/Event
☐ After activity ☐ While traveling

INJURED PERSON INFORMATION

Last Name	**First**	**Middle**	**Telephone Number ( )**	☐ Single ☐ Married
Address			**Social Security Number (optional)**	
City	**State**	**Zip**	**Employer and Address**	
Age	**D.O.B.**	☐ **Male** ☐ **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

INCIDENT LOCATION
☐ Competition area ☐ Concession area
☐ Parking lot ☐ Admission area
☐ Restrooms/locker rooms ☐ Off property
☐ Premises/grounds ☐ Store area
☐ Bleachers/stands

CLASSIFICATION
☐ Facility or event related ☐ Non-injury
☐ Not facility or event related
☐ Minor injury or illness
☐ Serious injury or illness

INCIDENT
☐ Assault/Sexual ☐ Slip, bodily reaction
☐ Assault/Non-Sexual ☐ Slip/Fall
☐ Fall (different level) ☐ Eligibility
☐ Fall (same level) ☐ Aquatic
☐Caught in, on, between ☐ Trip/Fall
☐ Animal/insect bite/sting ☐ Drug Testing
☐ Collision (with object) ☐ Overexertion
☐ Collision (participant/participant)
☐ Collision (participant/spectator)
☐ Collision (spectator/spectator)
☐ Struck by falling/flying object
☐Auto/Property

MEDICAL SERVICES
☐ Antacid ☐ Eye rinse
☐ Aspirin ☐ Glucose
☐ Aspirin substitute ☐ Ice Pack
☐ Bandaged ☐ Oxygen
☐ Ointment/antiseptic ☐ Rest
☐ Removal ☐ Splinted
☐ CPR ☐ Wrapped
☐ Cleansed ☐ Exam
☐ Cold Pack
☐ None

Treated By: _____

PRIMARY INJURY
☐ Allergy ☐ Dislocation ☐ Nausea
☐ Amputation ☐ Electrical Shock ☐ Stroke
☐ Abrasion ☐ Foreign Body ☐ Burn
☐ Laceration ☐ Fracture ☐ Death
☐ Drowning ☐ Heat Exhaustion ☐ Pain
☐ Hypertension ☐ Cardiac ☐ Illness
☐ Cold Injury ☐ Contusion ☐ Sting/bite
☐ Seizures ☐ Concussion
☐ Strain/Sprain ☐ Tooth/Mouth

BODY PART INJURED
☐ Eye (L/R) ☐ Torso ☐ Arm (L/R)
☐ Nose ☐ Back ☐ Tooth
☐ Neck ☐ Face ☐ Head
☐ Ear (L/R) ☐ Leg (L/R)
☐ Knee (L/R) ☐ Ankle (L/R)
☐ Internal ☐ Hip (L/R)
☐ Shoulder (L/R) ☐ Foot (L/R)
☐ Elbow (L/R) ☐ Hand (L/R)
☐ Wrist (L/R) ☐ Finger or Toe

DISPOSITION
☐ Released to parent ☐ Police
☐ Refusal of care ☐ Ambulance
☐ Refer to doctor ☐ Report only
☐ Refer to hospital or clinic
☐ Medical attention
☐ EMS transport
☐ Patient requested EMS transport
☐ Released to personal vehicle

Describe how the incident occurred:

WITNESS INFORMATION

NAME	ADDRESS	TELEPHONE NUMBER
1.		( )
2.		( )
3.		( )
4.		( )
5.		( )

Signature of Official (with no relationship to claimant) _____

Date: _____ Phone # _____

Send Completed Report to:

ACA
108 Hanover Street
Fredericksburg, VA 22401
Email: aca@americancanoe.org
Phone: (540) 907-4460
Fax: (888) 229-3792