



USA Track & Field INCIDENT REPORT FORM Injury or Property Damage

Incident Report Forms should be completed
And submitted to the National Office:
USA Track & Field
130 E. Washington Street, Suite 800
Indianapolis, IN 46204
Fax #: (800) 833-1466
POLICY #PHPK2050515

INJURED PERSON INFORMATION / PROPERTY DAMAGE OWNER

Last Name First Middle	Telephone	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Male <input type="checkbox"/> Female
Address	Employer and Address	
Date of Incident Time of Incident am / pm	Date of Birth	
INJURED PERSON: <input type="checkbox"/> Participant <input type="checkbox"/> Official <input type="checkbox"/> Coach <input type="checkbox"/> Spectator <input type="checkbox"/> Volunteer <input type="checkbox"/> Other:	EVENT: <input type="checkbox"/> USATF Sanctioned Event <input type="checkbox"/> USATF Member Club Practice	
NAME OF EVENT: Club Name: Association Name: USATF Membership #:	Does the injured person have other medical insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide name of company and policy #:	

GUARDIAN/PARENT (IF INJURED PERSON IS A MINOR)

Name	Telephone
Address, City, State, Zip	

INCIDENT INFORMATION

BODY PART INJURED <input type="checkbox"/> Ankle (L/R) <input type="checkbox"/> Shoulder (L/R) <input type="checkbox"/> Back <input type="checkbox"/> Knee (L/R) <input type="checkbox"/> Wrist (L/R) <input type="checkbox"/> Neck <input type="checkbox"/> Nose <input type="checkbox"/> Finger <input type="checkbox"/> Internal <input type="checkbox"/> Head <input type="checkbox"/> Eye (L/R) <input type="checkbox"/> No Injury <input type="checkbox"/> Tooth <input type="checkbox"/> Ear (L/R) <input type="checkbox"/> Other	If Ankle Injury, was ankle: <input type="checkbox"/> Taped <input type="checkbox"/> Supported <input type="checkbox"/> Unsupported Shoes: <input type="checkbox"/> Yes <input type="checkbox"/> No If Knee Injury, was knee: <input type="checkbox"/> Braced <input type="checkbox"/> Supported <input type="checkbox"/> Unsupported Knee Pads: <input type="checkbox"/> Yes <input type="checkbox"/> No	INCIDENT OR PROPERTY DAMAGE <input type="checkbox"/> Collision (participant/spectator) <input type="checkbox"/> Collision (with object) <input type="checkbox"/> Slip/Fall <input type="checkbox"/> Collision (participant/participant) <input type="checkbox"/> Overexertion <input type="checkbox"/> Collision (spectator/spectator) <input type="checkbox"/> Assault/Sexual <input type="checkbox"/> Struck by falling/flying object <input type="checkbox"/> Assault/Non-Sexual <input type="checkbox"/> Caught in, on, between <input checked="" type="checkbox"/> Property Damage <input type="checkbox"/> Animal/insect bite/sting	
COURT SURFACE <input type="checkbox"/> Concrete <input type="checkbox"/> Asphalt <input type="checkbox"/> Grass <input type="checkbox"/> Sand <input type="checkbox"/> Wood <input type="checkbox"/> Sport Court If sport court, what is underlying surface? <input type="checkbox"/> Wood <input type="checkbox"/> Concrete <input type="checkbox"/> Asphalt	INCIDENT LOCATION <input type="checkbox"/> Before Competition/Event <input type="checkbox"/> During Competition/Event <input type="checkbox"/> After Competition/Event <input type="checkbox"/> Competition area <input type="checkbox"/> Concession area <input type="checkbox"/> Parking lot <input type="checkbox"/> Admission area <input type="checkbox"/> Restrooms/locker rooms <input type="checkbox"/> Off property <input type="checkbox"/> Bleachers/stands <input type="checkbox"/> Merchandise Area	PRIMARY INJURY <input type="checkbox"/> Allergy <input type="checkbox"/> Dislocation <input type="checkbox"/> Amputation <input type="checkbox"/> Nausea <input type="checkbox"/> Foreign Body <input type="checkbox"/> Burn <input type="checkbox"/> Laceration <input type="checkbox"/> Fracture <input type="checkbox"/> Heat Exhaustion <input type="checkbox"/> Pain <input type="checkbox"/> Hypertension <input type="checkbox"/> Cardiac <input type="checkbox"/> Cold Injury <input type="checkbox"/> Contusion <input type="checkbox"/> Electrical Shock <input type="checkbox"/> Seizures <input type="checkbox"/> Strain/Sprain <input type="checkbox"/> Concussion <input type="checkbox"/> Abrasion <input type="checkbox"/> Sting/bite <input type="checkbox"/> Illness <input type="checkbox"/> Death	DISPOSITION <i>No care given:</i> <input type="checkbox"/> Patient refused <input type="checkbox"/> Not needed <i>Released:</i> <input type="checkbox"/> To parent <input type="checkbox"/> To personal vehicle <i>Referral:</i> <input type="checkbox"/> To doctor <input type="checkbox"/> To hospital/clinic <i>EMS transport:</i> <input type="checkbox"/> Trainer recommended <input type="checkbox"/> Patient/parent requested

Describe how the injury or **property** damage occurred: (attach a separate sheet if necessary)

WITNESS INFORMATION

Name	Address	Telephone Number
1.		
2.		

Tournament Director, Club Director, Coach and/or USA Track & Field Official completing this form:

Name: _____ Signature: _____ Title: _____ Date: _____ Phone #: (____) _____