

Team River Runner Incident Report Form

Please submit a signed waiver for injured person, along with this form, within 48 hours of incident
Two page form must be completed by official chapter representative – please print legibly

Date of Incident:		Time of Incident:	
Chapter Name:		State:	
Executive Director:		Exec. Dir. Email:	
INJURED PERSON INFORMATION			
First Name:		Middle Initial:	Last Name:
Phone Number:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	
Address:		City:	State: Zip:
Disability:			<input type="checkbox"/> N/A
Injured Person: <input type="checkbox"/> Participant <input type="checkbox"/> Employee <input type="checkbox"/> Volunteer <input type="checkbox"/> 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:		BODY PART INJURED:	
<input type="checkbox"/> Abrasion	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Ankle (L / R)	<input type="checkbox"/> Internal
<input type="checkbox"/> Allergy	<input type="checkbox"/> Hypothermia	<input type="checkbox"/> Arm (L / R)	<input type="checkbox"/> Knee (L / R)
<input type="checkbox"/> Amputation	<input type="checkbox"/> Laceration	<input type="checkbox"/> Back	<input type="checkbox"/> Leg (L / R)
<input type="checkbox"/> Burn	<input type="checkbox"/> Illness	<input type="checkbox"/> Ear (L / R)	<input type="checkbox"/> Neck
<input type="checkbox"/> Cardiac	<input type="checkbox"/> Nausea	<input type="checkbox"/> Elbow (L / R)	<input type="checkbox"/> Nose
<input type="checkbox"/> Cold Injury	<input type="checkbox"/> Pain	<input type="checkbox"/> Eye (L / R)	<input type="checkbox"/> Shoulder (L / R)
<input type="checkbox"/> Concussion	<input type="checkbox"/> Seizures	<input type="checkbox"/> Face	<input type="checkbox"/> Toe
<input type="checkbox"/> Contusion	<input type="checkbox"/> Sting/Bite	<input type="checkbox"/> Finger	<input type="checkbox"/> Tooth
<input type="checkbox"/> Dislocation	<input type="checkbox"/> Strain/Sprain	<input type="checkbox"/> Foot (L / R)	<input type="checkbox"/> Torso
<input type="checkbox"/> Foreign Body	<input type="checkbox"/> Stroke	<input type="checkbox"/> Hand (L / R)	<input type="checkbox"/> Wrist (L / R)
<input type="checkbox"/> Fracture	<input type="checkbox"/> Tooth/Mouth	<input type="checkbox"/> Head	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Heat Exhaustion	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Hip	
INCIDENT INFORMATION			
PRIMARY CAUSE OF INCIDENT:			
<input type="checkbox"/> Animal bite/sting	<input type="checkbox"/> Assault/non-sexual	<input type="checkbox"/> Collision with person	<input type="checkbox"/> Struck by falling /flying object
<input type="checkbox"/> Aquatic	<input type="checkbox"/> Caught in, on, between	Fall/Slip	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Assault/sexual	<input type="checkbox"/> Collision with object	<input type="checkbox"/> Fall from height	_____
INCIDENT LOCATION: <input type="checkbox"/> Activity Site <input type="checkbox"/> Administrative Premises/Grounds <input type="checkbox"/> Off Property <input type="checkbox"/> Other: _____			
INCIDENT TOOK PLACE DURING:			
<input type="checkbox"/> Lesson <input type="checkbox"/> Competition <input type="checkbox"/> Training <input type="checkbox"/> Guiding <input type="checkbox"/> Other: _____			
WEATHER CONDITIONS: <input type="checkbox"/> Clear <input type="checkbox"/> Icy <input type="checkbox"/> Fog <input type="checkbox"/> Rain <input type="checkbox"/> Snow <input type="checkbox"/> N/A <input type="checkbox"/> Other: _____			
INCIDENT TOOK PLACE DURING WHAT SPORT/ACTIVITY:			
EQUIPMENT INVOLVED IN INCIDENT:			

PLEASE COMPLETE 2ND PAGE

The completed incident report is an internal document and may only be shared with Team River Runner National Headquarters.

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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:

- | | | |
|---|---|--|
| <input type="checkbox"/> Transported by ambulance to hospital | <input type="checkbox"/> Referred to doctor | <input type="checkbox"/> Ski patrol assisted |
| <input type="checkbox"/> Transported by air ambulance to hospital | <input type="checkbox"/> Referred to hospital or clinic | <input type="checkbox"/> Police involved |
| <input type="checkbox"/> Transported by ambulance to hospital at the request of patient/parent/guardian | <input type="checkbox"/> Released to parent/guardian | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Self-transported to hospital or clinic | <input type="checkbox"/> Released to self | _____ |

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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