

# 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:	
<b>INJURED PERSON INFORMATION</b>			
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: _____			
<b>PARENT/LEGAL GUARDIAN (IF INJURED PERSON IS A MINOR OR LEGALLY INCAPACITATED)</b>			
First Name:		Last Name:	Phone Number:
Address:		City:	State: Zip:
<b>INJURY INFORMATION</b>			
<b>PRIMARY INJURY RESULTING FROM INCIDENT:</b>		<b>BODY PART INJURED:</b>	
<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	
<b>INCIDENT INFORMATION</b>			
<b>PRIMARY CAUSE OF INCIDENT:</b>			
<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	_____
<b>INCIDENT LOCATION:</b> <input type="checkbox"/> Activity Site <input type="checkbox"/> Administrative Premises/Grounds <input type="checkbox"/> Off Property <input type="checkbox"/> Other: _____			
<b>INCIDENT TOOK PLACE DURING:</b>			
<input type="checkbox"/> Lesson <input type="checkbox"/> Competition <input type="checkbox"/> Training <input type="checkbox"/> Guiding <input type="checkbox"/> Other: _____			
<b>WEATHER CONDITIONS:</b> <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: _____			
<b>INCIDENT TOOK PLACE DURING WHAT SPORT/ACTIVITY:</b>			
<b>EQUIPMENT INVOLVED IN INCIDENT:</b>			

PLEASE COMPLETE 2ND PAGE

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

