TUCSON YOUTH FOOTBALL AND SPIRIT FEDERATION, INC. “INJURY REPORT FORM”

INSTRUCTIONS: This form is to be completed by the attending Medical person (with assistance from the Team Business Manager) for any injury that requires referral to a physician or hospital or immediate medical treatment. This report must be signed by both the attending Medical person and the Team Business Manager. All injuries must be reported within three (3) days.

Print Clearly

Participants Name: ___________________________________________ Jersey Number: ________________
Date of Injury: _______________________________ Time: ________________ Quarter: ________________
Association: __________________ Division: __________________ Team: ________________ Coach: ________________

EVENT (Circle Appropriate Number)
1. Practice  3. Game  5. Other (describe):
2. Scrimmage  4. Transportation to/from ____________________________

EQUIPMENT (Circle Appropriate Number):
1. Full  2. Helmet Only  3. None

POSITION (Circle Appropriate Number)
1. Defensive Line  3. Offensive Line  5. Other
2. Defensive Backfield  4. Offensive Backfield ____________________________

LOCATION OF INJURY (Indicate if left or right, and circle number on the injury)

Right ____________________________ Left ________________________________
8. Others ______________________________________________________________________________

TYPE OF INJURY (Circle the number of the known or suspected nature of injury. In case of multiple injuries, Number the circles to correspond to the injury on the previous section).

2. Sprain/Strain  5. Laceration  8. Other (describe)
3. Tear  6. Dislocation/Sublimation ____________________________

TREATMENT (Circle appropriate number)
1. Ice  5. Compression  8. Taping/Splinting
2. Observation  6. Returned to team/game  9. Other (describe)
3. Request Ambulance  7. Referral to Physician ____________________________
4. Transferred by other (name) ____________________________________________

EVALUATION/ASSESSMENT OF INJURIES (briefly describe the athlete’s chief complaint and your suspicions of the nature of the injury):
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________

Attending Medical Person (print name and credentials): ____________________________________________
Medical Person Signature: ____________________________________________ Date: ________________________________
Team Business Manager Signature: ____________________________________________ Date: ________________________________

Form Distribution: Original – Problem Resolution Committee Copy – Participate/Parent Copy – Team Business Records