EPIC Soccer Club Injury Report Form: This form is NOT to be completed by a parent.

INJURED PERSON: ☐Player ☐Official ☐Coach ☐Spectator ☐Other_____

DATE: **TIME:** ☐am ☐pm | **TEAM 1:** **TEAM 2:**

NAME:_____ ☐Male ☐Female **BIRTHDATE:**_____

ADDRESS:_____ **CITY:**_____ **STATE:**_____ **ZIP:**_____

EMAIL:_____ **PHONE:**_____

NAME OF PARENT/GUARDIAN (If injured person is a minor):_____

NAME OF VENUE:

FIELD SURFACE:

☐Grass
☐Turf
☐Dirt
☐Indoor
☐Pavement
☐Cement
☐Rubberized surface
☐Other_____

ADDRESS: _____

CITY:_____

STATE:_____ **ZIP:**_____

TYPE OF PLAY AT TIME OF INJURY:

☐Training/Practice

☐Scrimmage

☐Game

☐Other_____

REASON FOR INJURY:

☐New Injury
☐Aggravated Injury
☐Recurrent Injury
☐Illness
☐Other_____

Was protective equipment worn on the injured body part?
☐Yes ☐No
Type?(tape, brace, Shin guard, mouth guard, etc.)
_____

BODY PART INJURED: ☐Left ☐Right ☐NA

☐Head	☐Neck	☐Finger	☐Foot
☐Eye	☐Back	☐Thumb	☐Toe
☐Ear	☐Chest	☐Thigh	☐Internal
☐Cheek	☐Shoulder	☐Knee	☐None
☐Nose	☐Elbow	☐Leg	
☐Chin	☐Arm	☐Shin	
☐Mouth	☐Wrist	☐Ankle	
☐Tooth	☐Hand	☐Other_____	

NATURE OF INJURY/ILLNESS:

☐Abrasion/Scratch	☐Contusion	☐Burn
☐Laceration	☐ Respiratory	☐Pain
☐Puncture	☐Contusion	☐Nausea
☐Avulsion	☐Seizures	☐Illness
☐Fracture	☐Cold Related	☐Cardiac
☐Dislocation	☐Heat Related	
☐Subluxation	☐Allergy Related	
☐Sprain	☐Concussion	
☐Strain	☐Other_____	
☐Loss of Consciousness		

DESCRIPTION OF INJURY:

_____

_____

_____

_____

TIME:

☐ Before event

☐ During event

☐ After event

LOCATION:

☐ Playing field
☐ Sideline
☐ Concession area
☐ Restrooms
☐ Bleachers/Stands
☐ Parking lot
☐ Storage area
☐ Other_____

HOW DID IT HAPPEN:

☐ Collision with a player/referee
☐ Collision with an object
☐ Collision with a spectator
☐ Struck by a player
☐ Struck by an object
☐ Struck by ball
☐ Heading the ball
☐ Fall/stumble on same level
☐ Fall/stumble from a height
☐ Overstretch
☐ Overexertion
☐ Insect bee/sting
☐ Overuse
☐ Slip/Trip
☐ Temperature related (heat stress)
☐ Other_____

EXIT FROM INJURY SITE:

☐ Assisted by coach
☐ Assisted by players
☐ Assisted by _____
☐ Carried by coach
☐ Carried by players
☐ Carried by _____
☐ Ambulance
☐ Personal Vehicle

IF TREATED AT HOSPITAL:

☐ Transported by ambulance
☐ Transported by personal vehicle

IMMEDIATE TREATMENT:

☐ No treatment required
☐ Player refused treatment
☐ Parent refused treatment
☐ CPR
☐ AED
☐ Spine stabilization
☐ Ice, Compression, Elevation
☐ Rest
☐ Wound care
☐ Dressing for cuts/abrasions,etc.
☐ Sling
☐ Splint
☐ Brace
☐ Crutches
☐ Taping
☐ Stretching
☐ Fluids
☐ Food

CARE PROVIDED BY (name):

☐ Coach
_____

☐ Parent
_____

☐ Nurse
_____

☐ Athletic Trainer, Certified
_____

☐ Physician
_____

☐ EMS
☐ Other_____

RETURN TO PLAY SAME DAY:

☐ Able to return, no restrictions
☐ Able to return, restrictions
☐ Able to return, but did not
☐ Unable to return to play

ADVICE GIVEN:

☐ Parents were notified
☐ No referral
☐ Referred to medical personnel
☐ Ambulance transport
☐ Hospital
☐ Need for x-rays
☐ Concussion Information
☐ Further assessment before allowed to return to activity
☐ Other_____
_____
_____

Person Completing Form:	**Position Title:**
Address:	**Phone:**
Email:	
Signature:	**Date:**

Note: Persons without medical training should refer all medical decisions to appropriately qualified professionals. DO NOT attempt to diagnose injuries/illnesses. If the injured person's injury/illness does NOT improve in the following 24 hours, they MUST seek advice from their medical professional.
***Any head injury requires a doctor's approval for return to play.**