



# CLUB SPORT INJURY REPORT

**Name of Injured Individual:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
Street City State Zip

**Phone:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Club Sport:** \_\_\_\_\_

**800 #:** \_\_\_\_\_  Not a Brockport student

**Emergency Contact Information**

**Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Relationship to Injured Party:** \_\_\_\_\_

**Where did this accident occur?**       On-campus facility       Off-campus facility

**If on-campus, please indicate specific location where accident occurred:**

<input type="checkbox"/> Baseball Field (Game or Practice)	<input type="checkbox"/> SERC Group Ex Studio	<input type="checkbox"/> Tuttle North Gymnastics Room
<input type="checkbox"/> Bob Boozer Turf Field	<input type="checkbox"/> Softball Field	<input type="checkbox"/> Tuttle North Ice Arena
<input type="checkbox"/> Cooper Hall Gym	<input type="checkbox"/> Tennis Court	<input type="checkbox"/> Tuttle North Pool
<input type="checkbox"/> Hartwell Dance Studio	<input type="checkbox"/> Tuttle North Front Gym	<input type="checkbox"/> Tuttle South Gym
<input type="checkbox"/> SERC Field House	<input type="checkbox"/> Tuttle North Back Gym	<input type="checkbox"/> X-Lot Field
		<input type="checkbox"/> Other: _____

**If off-campus, please provide the name and location of the facility** \_\_\_\_\_

**Date and time of injury (MM/DD/YY):** \_\_\_\_/\_\_\_\_/\_\_\_\_ : \_\_\_\_ am/pm (Circle one)

**Exact location of injury (Body part, right or left, etc.):** \_\_\_\_\_

**Describe exactly HOW injury occurred:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Was this a Head/Neck Injury?**       Yes    No   **If yes, please complete other side of this form.**

**Treatment Provided (Provider & action taken):** \_\_\_\_\_

\_\_\_\_\_

**Name, address and phone number of others involved in the injury/witnesses to the injury:** \_\_\_\_\_

\_\_\_\_\_

**Destination of Injured Individual: (\*911/Univ. Police 395-2222/EMS must be called if this is a life-threatening injury\*)**

Home       Returned to activity       Hospital – Name: \_\_\_\_\_

Other – Describe: \_\_\_\_\_

**Name of Club Sport Officer filling out report (print):** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of Injured Individual:** \_\_\_\_\_

**INDIVIDUALS WHO SUSTAIN A HEAD OR NECK INJURY MAY NOT RETURN TO ACTIVITY ON THE SAME DAY.**

**Complete the next parts of this form with the injured individual. Check YES or NO for symptoms observed or reported.**

**Observed Symptoms**

Vacant Stare/Glassy Eyed	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Poor Balance/Coordination	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Slurred Speech	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Change in Personality/Irritability	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Unconsciousness	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Nausea/Vomiting	<input type="checkbox"/> YES	<input type="checkbox"/> NO

If yes, approximately how long? \_\_\_\_\_

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**Reported Symptoms**

Do you feel dizzy?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Do you know where you are?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Are your ears ringing?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Do you have a headache?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you feel drowsy/sleepy or fatigued/low on energy?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Are you sensitive to loud noises?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Are you experiencing any weakness/tingling in your arms or legs?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Do you remember how you were injured?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Does it bother you to look at a light?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Is your vision blurred/are you experiencing double vision?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you feel dazed/like something isn't right?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Are you experiencing any neck pain/tenderness?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

Other: \_\_\_\_\_

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**Office Use Only**

Received by: \_\_\_\_\_

Date received: \_\_\_\_\_

Director's Signature: \_\_\_\_\_

Date received: \_\_\_\_\_

**PLEASE COMPLETE THIS FORM AND RETURN IT TO THE CAMPUS RECREATION DEPARTMENT IN THE SERC ON THE NEXT BUSINESS DAY.**