

INJURY REPORT FORM

What to do with this form:
A Take to Games Official immediately following the game
B Games Official:
 1) Fax to BBNSW on (02) 87655588
 2) Keep a copy for BBBA injury record book
 3) For away games, a copy of the form must also be forwarded to the HOME Association of the injured player

Venue injury occurred: _____ Competition: _____

Team Name: _____ Date of injury: _____ Name of injured: _____ Date of birth: _____

Registration No. _____ Grade: _____ Gender: Male Female

Injured person was: Player Referee Coach Spectator Other _____

Activity at time of injury: Home Competition Away Competition Rep Competition Training Other _____

Body part(s) injured (i.e. left elbow, face – above eye): _____

Name of witness to injury: _____ Witness contacts: Ph. _____ Referee Name _____

<p>Type of injury:</p> <p><input type="checkbox"/> abrasion/graze <input type="checkbox"/> sprain/strain</p> <p><input type="checkbox"/> open wound <input type="checkbox"/> bruise</p> <p><input type="checkbox"/> inflammation/swelling <input type="checkbox"/> overuse injury</p> <p><input type="checkbox"/> dislocation <input type="checkbox"/> cardiac problem</p> <p><input type="checkbox"/> fracture (include suspected) <input type="checkbox"/> respiratory</p> <p><input type="checkbox"/> concussion/lost consciousness</p> <p><input type="checkbox"/> other: _____</p>	<p>Cause of injury:</p> <p><input type="checkbox"/> struck by other player <input type="checkbox"/> struck by ball or object</p> <p><input type="checkbox"/> collision with fixed object <input type="checkbox"/> fall/stumble</p> <p><input type="checkbox"/> slip/trip <input type="checkbox"/> temperature related</p> <p><input type="checkbox"/> jumping to shoot/defend/rebound</p> <p><input type="checkbox"/> collision with other player/referee</p> <p><input type="checkbox"/> gradual onset, no cause identified</p> <p><input type="checkbox"/> other: _____</p> <p>Explain exactly how the incident occurred:</p>	<p>Initial treatment:</p> <p><input type="checkbox"/> none required <input type="checkbox"/> dressing</p> <p><input type="checkbox"/> ice/RICER <input type="checkbox"/> strapping/ taping</p> <p><input type="checkbox"/> other: _____</p> <p>Treatment provided by: _____</p> <p>Did injured person go to hospital? <input type="checkbox"/> no <input type="checkbox"/> unknown</p> <p><input type="checkbox"/> yes <input type="checkbox"/> by ambulance <input type="checkbox"/> by car</p>
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Details of person completing this form:

Name: _____ Ph: _____ Mob: _____

Position/Role _____ Signature: _____ Date: _____