

**CAMPUS RECREATION SERVICES SPORT CLUBS  
ACCIDENT REPORT FORM**

Day \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_

Name of Injured \_\_\_\_\_ Male / Female \_\_\_\_\_ Age \_\_\_\_\_

SID# \_\_\_\_\_ Local Address \_\_\_\_\_

Phone # \_\_\_\_\_ E-mail: \_\_\_\_\_

Circle the following: Student Faculty/Staff Alumni

Time accident occurred: \_\_\_\_\_ AM / PM

Club Name: \_\_\_\_\_

Time accident reported: \_\_\_\_\_ AM / PM

**Part of body injured:** check one ☞

- |                                  |                                  |                                   |
|----------------------------------|----------------------------------|-----------------------------------|
| <input type="checkbox"/> Left    | <input type="checkbox"/> Right   |                                   |
| <input type="checkbox"/> Abdomen | <input type="checkbox"/> Face    | <input type="checkbox"/> Leg      |
| <input type="checkbox"/> Ankle   | <input type="checkbox"/> Finger  | <input type="checkbox"/> Mouth    |
| <input type="checkbox"/> Arm     | <input type="checkbox"/> Foot    | <input type="checkbox"/> Nose     |
| <input type="checkbox"/> Back    | <input type="checkbox"/> Forearm | <input type="checkbox"/> Ribs     |
| <input type="checkbox"/> Chest   | <input type="checkbox"/> Hand    | <input type="checkbox"/> Scalp    |
| <input type="checkbox"/> Ear     | <input type="checkbox"/> Head    | <input type="checkbox"/> Shoulder |
| <input type="checkbox"/> Elbow   | <input type="checkbox"/> Hip     | <input type="checkbox"/> Tooth    |
| <input type="checkbox"/> Eye     | <input type="checkbox"/> Knee    | <input type="checkbox"/> Thigh    |
| <input type="checkbox"/> Wrist   | Other (specify) _____            |                                   |

Nature of Injury (Key Words):

\_\_\_\_\_  
(sprain, fracture, bruise, etc)

Brief Description: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Specific Location:** check one ☞

- |   |                                       |
|---|---------------------------------------|
| <input type="checkbox"/> BU Gym I             | <input type="checkbox"/> BU Field     |
| <input type="checkbox"/> BU Gym II            | <input type="checkbox"/> Classroom    |
| <input type="checkbox"/> BU Gym III           | <input type="checkbox"/> Newell Field |
| <input type="checkbox"/> Pool                 | <input type="checkbox"/> Tennis Cts.  |
| <input type="checkbox"/> Outdoor Trips Center | <input type="checkbox"/> Locker room  |
| <input type="checkbox"/> Weightroom           | <input type="checkbox"/> Hallway      |
| <input type="checkbox"/> Mezzanine            | <input type="checkbox"/> Stairs       |

Activity: \_\_\_\_\_

Peregrine's Nest

Bouldering Wall

Other

Specify Activity: \_\_\_\_\_

**Immediate Action Taken: EXPLAIN**

First Aid \_\_\_\_\_

Sent to Health Center \_\_\_\_\_

Sent to Hospital \_\_\_\_\_

Refused Attention (get initials) \_\_\_\_\_

Other (specify) \_\_\_\_\_

**Method of Transportation:**

- |  |  |
|--|--|
| <input type="checkbox"/> Ambulance     | <input type="checkbox"/> Private Vehicle |
| <input type="checkbox"/> Campus Police | <input type="checkbox"/> Other (specify) |

**Witness Available:** Yes \_\_\_\_\_ No \_\_\_\_\_ Signature \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_

Phone \_\_\_\_\_

**On a separate sheet of paper, all witnesses should write a full account of what happened in their own words.**

Injured Signature: \_\_\_\_\_ Date \_\_\_\_\_

Report Filled Out By: \_\_\_\_\_ Date \_\_\_\_\_

**This form should be returned to the Sport Clubs Office in BU 150 as soon as possible.**

**Post Follow Up Report:**

Assistant Director: \_\_\_\_\_ Date: \_\_\_\_\_

Method of Contact: \_\_\_\_\_

Results: \_\_\_\_\_