



Date of incident: _____ Time: _____ am/pm

Name of injured person: _____

Address: _____

Phone Number (s): _____

Date of birth: _____ Male: _____ Female: _____

Do you have a copy of the injured persons consent form? Yes No

Who was injured person? Participant Staff Parent/Adult

Type of injury: _____

Details of incident:

Injury requires physician/hospital visit? Yes No

Name of physician/hospital: _____

Address: _____

Physician/hospital phone number: _____

Signature of injured party

Date

*No medical attention was desired and/or required.

Signature of injured party

Date

Form completed by:

Name:

Signature

Date

Next in line Scouter:

Name:

Signature

Date