Campus Recreation

Club Sport – Injury Report

Name of Injured Individual: ______________________ Sport Club: ______________

Date of Birth: ______ Brockport ID#: ____________ ☐ Not a Brockport Student

Address: ______________________________ Phone Number: ____________

Address where injury occurred: ______________________________

Date of Injury: ________ Time of Injury: _______ ☐ AM ☐ PM

Was medical assistance summoned? ☐ Yes ☐ No

Exact location of injury (Body part, right or left, etc.): ______________________

Describe exactly how injury occurred (attach additional pages if necessary): ____________

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Treatment provided (Provider, action taken): ______________________________

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Destination of Injured Individual:

☐ Home ☐ Returned to Activity ☐ Hospital – Name: __________________

☐ Other – Describe: ______________________________________

Name, address, and phone number of witness(es):

1. ____

2. ____

Name of reporter filling out form (print): ______________________ Date: ________

Address: ______________________________ Phone Number: ____________

Was this a head/neck injury? ☐ Yes ☐ No If yes, please complete other side of this form.

This section to be completed for all injuries where a head or neck injury is suspected, reported, or observed. Please complete this section as soon as it is safely possible to do so following the initial injury.

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

Check YES or NO for symptoms observed or reported at the time of injury:

Symptom	Response	Symptom	Response
Dizziness	☐ Yes ☐ No	Unconsciousness	☐ Yes ☐ No
Ringing in Ears	☐ Yes ☐ No	Fatigue/Low Energy	☐ Yes ☐ No
Drowsy/Sleepy	☐ Yes ☐ No	Feeling Dazed	☐ Yes ☐ No
“Doesn’t Feel Right”	☐ Yes ☐ No	Poor Balance/Coordination	☐ Yes ☐ No
Memory Problems	☐ Yes ☐ No	Loss of Orientation	☐ Yes ☐ No
Blurred Vision	☐ Yes ☐ No	Sensitivity to Light	☐ Yes ☐ No
Vacant Stare/Glassy Eyed	☐ Yes ☐ No	Sensitivity to Sound	☐ Yes ☐ No
Irritability	☐ Yes ☐ No	Change in Personality	☐ Yes ☐ No
Headache	☐ Yes ☐ No	Nausea/Vomiting	☐ Yes ☐ No
Slurred Speech	☐ Yes ☐ No		

Other: ____

If there was a loss of consciousness, approximately how long was the person unconscious? ___________

Did the individual have an altered state of consciousness after the injury? ☐ Yes ☐ No

Signature of Individual: ___________________________ ☐ Individual unwilling/unable to sign

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Office Use Only

Received by: ___________________________________ **Date Received:** _____________

Director’s Signature: _____________________________ **Date Received:** _____________

Copies Sent to: ☐ **Human Resources** ☐ **Student Health Services**

<u>**Head Injuries Only**</u>

Emergency Contact Notified? ☐ **Yes** ☐ **No**

Medical clearance received from primary HCP? ☐ **Yes** ☐ **No** **Date:** ________

Medical clearance received from SHS? ☐ **Yes** ☐ **No** **Date:** ________

Individual eligible to return to activity? ☐ **Yes** ☐ **No**

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