

Dundalk St. Gerard's Athletic Club



ACCIDENT REPORT FORM

(This form should be completed whenever an accident involving injury to person or damage to property occurs)

Name of person involved in accident: _____

Address: _____

Phone: _____

Athlete, Coach, Spectator, Parent, Visitor, Other: _____

Registered with Athletic Association of Ireland (AAI): Yes: ☐ No: ☐ Put an 'x' in the appropriate box

What activity did the person involved engage in: _____

Particulars of accident: _____

Location where the accident took place: _____

Time: _____ Date: _____

Witnesses: _____ Phone No.: _____

Address: _____

Record names, addresses and phone numbers of other witnesses overleaf

When and to whom the accident was initially reported: _____

Particulars of accident: Circumstances under which it occurred:

use additional pages if necessary

Details of injury:

Indicate type of injury (put an 'x' in one box only)

- | | |
|--|--|
| <input type="checkbox"/> Bruising, contusion | <input type="checkbox"/> Suffocation, asphyxiation |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Gassing |
| <input type="checkbox"/> Internal injuries | <input type="checkbox"/> Drowning |
| <input type="checkbox"/> Open wound | <input type="checkbox"/> Poisoning |
| <input type="checkbox"/> Abrasion, graze | <input type="checkbox"/> Infection |
| <input type="checkbox"/> Amputation | <input type="checkbox"/> Burns, scalds and frostbite |
| <input type="checkbox"/> Open fracture (i.e. bone exposed) | <input type="checkbox"/> Effects of radiation |
| <input type="checkbox"/> Closed fracture | <input type="checkbox"/> Electrical injury |
| <input type="checkbox"/> Dislocation | <input type="checkbox"/> Injury not ascertained |
| <input type="checkbox"/> Sprain, torn ligaments | <input type="checkbox"/> Other, please specify _____ |

Indicate part of body most seriously injured (put an 'x' in one box only)

- | | |
|---|---|
| <input type="checkbox"/> Head, except eyes | <input type="checkbox"/> Fingers, one or more |
| <input type="checkbox"/> Eyes | <input type="checkbox"/> Hip joint, thigh, knee cap |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Knee joint, lower leg, ankle |
| <input type="checkbox"/> Back, spine | <input type="checkbox"/> Foot |
| <input type="checkbox"/> Chest | <input type="checkbox"/> Toes, one or more |
| <input type="checkbox"/> Abdomen | <input type="checkbox"/> Extensive parts of the body |
| <input type="checkbox"/> Shoulder, upper arm, elbow | <input type="checkbox"/> Multiple injuries |
| <input type="checkbox"/> Lower arm, wrist, hand | <input type="checkbox"/> Other, Please specify _____ |

Consequences of the accident

Severity:

Fatal ☐
Non-Fatal ☐

Anticipated absence from usual occupation:

None <input type="checkbox"/>	8-14 days <input type="checkbox"/>
1-3 days <input type="checkbox"/>	More than 14 days <input type="checkbox"/>
4-7 days <input type="checkbox"/>	Permanently <input type="checkbox"/>

Treatment: _____

Doctors report and recommendation:

Steps taken to prevent reoccurrence of this type of accident: _____

Other comments relating to the accident: _____

Signature of person completing report: _____ Date: _____

Print name and Position: _____

Signature of Chairman/Secretary: _____ Date: _____

Print name: _____

(Copies of the completed Accident Report Form are to be filed with the secretary of Dundalk St. Gerard's AC and discussed at the next possible committee meeting.)