



Georgetown Soccer Club Accident Report Form

Date of Report: _____
dd/mm/yyyy

Patient Information

Last Name:	First Name:
Address:	City:
Postal Code:	Telephone:
E-Mail:	DOB: _____ dd/mm/yyyy
Gender: ____ (M) ____ (F)	Height: _____ Weight: _____
Known medical conditions/allergies:	

Incident Information

Date/Time of Incident: _____ AM/PM dd/mm/yyyy	Time of First Intervention: _____ AM/PM	Time of Medical Support Arrival (if applicable): _____ AM/PM
Charge Person to describe incident (what took place, where it took place, signs and symptoms of patient):		
Patient to describe incident (see above):		
Event and Conditions (event during which incident occurred, location of incident, weather, etc):		
Actions Taken/Intervention:		
After treatment, the patient was: _____ Sent home _____ Sent to hospital/clinic _____ Returned to activity		



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Charge Person Information

Last Name:	First Name:
Address:	City:
Postal Code:	Telephone:
E-Mail:	Role (ie, coach):

Witness Information (someone other than the charge person who observed the incident and response)

Last Name:	First Name:
Address:	City:
Postal Code:	Telephone:
E-Mail:	Role (ie, bystander):

Other Comments or Remarks

Form Completed by:

Print Name

Signature

Once completed, please submit to GSC office.