girl scouts heart of michigan

Incident/Accident Report Form

Please complete within 24 hours of incident/accident

Name of Injured ____
First Middle Last

Age ________ Sex __________ ❑ Participant ❑ Staff ❑Visitor

Address____
Street & Number City State Zip

If Minor, Name of Parent/Guardian____

Address____
Street & Number City State Zip

Names/Addresses of Witnesses (Attach signed statements as to incident):

1. ____
2. ____
3. ____

Date of Accident/Incident ______________________ Hour ________a.m. ________ p.m.
Day Month Date Year

Facility Name ____ Date ______________

Address ____
Street & Number City State Zip

Where incident/accident occurred? (Specify location, including location of injured and witnesses. Use diagram to locate persons and objects).

____

____

____

Describe incident/accident in detail: (Use additional pages if necessary) ____

____

____

____

Was individual participating in an activity at the time of the incident/accident? _____ If so what? __________________

Was any equipment involved in the incident/ accident? ____

____

What could have been done to prevent the injury/incident? ____

____

____

What emergency procedures were followed at time of accident? ____

____

____

Who administered the emergency care? ____

- OVER –

Medical Report of Accident:

Were family notified? _____ In writing? _____ By phone? ______ Other ________________________

By whom? ________________________________ Date ________________________Time________

Where was treatment given? At facility ______ Urgent Care _____ Dr. Office _____ Hospital _____

By whom? __________________________________ Date __________________ Time____________

Describe treatment administered: ____

Facility Name: ____

City:_____________________________ Date _____________ Inpatient _______ Out patient _____

Name of Physician in attendance ____

Date released from hospital ____

Comments:____

Submitted by ______________________________ Position _________________ Date ___________

Office Use Only:
Insurance Claim submitted: Date: ________________ Copy participant insurance card ____________

- ❑ Mutual of Omaha
- ❑ Workman's Compensation

Payment received ______________________