

# XAVIER UNIVERSITY RECREATIONAL SPORTS DEPARTMENT ACCIDENT REPORT

Date of Report \_\_\_\_\_ Date of Accident \_\_\_\_\_ Time of Accident \_\_\_\_\_ AM or PM

## PERSONAL DATA

Name of Injured \_\_\_\_\_ XU I.D. Number \_\_\_\_\_  
 Local Address \_\_\_\_\_  
 Local Phone \_\_\_\_\_ Gender: Male / Female  
 Date of Birth \_\_\_\_\_  
 Status of Injured:  Student  Faculty  Staff  Guest  OSC Member  
 Other (Please Specify) \_\_\_\_\_  
 Injured Person's Nearest Relative (Name/Address/Phone #) \_\_\_\_\_

## DETAILS OF ACCIDENT

Location of Accident:  OSC Basketball Courts  Soccer Field  Armory  
 OSC Racquetball Courts  Sherman Field  Fieldhouse  
 OSC Pool  Park Field  
 OSC Locker Room  Tennis Courts  
 OSC Hammer Strength Rm.  Sand Volleyball Courts  
 OSC Cardio Room  Other \_\_\_\_\_

Program Participated In:  Intramural Sports  Club Sports  Special Event  
 Informal Rec.  Rental  Fitness Class  
 Other (Please Specify) \_\_\_\_\_

## HOW DID INJURY OCCUR?

Collision w/Obstacle  Collision w/Participant  Collision w/Playing Surface  
 Equipment Related  Non-Contact  Unknown  
 Other (Please Specify) \_\_\_\_\_

DESCRIBE MORE SPECIFICALLY: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## PART OF BODY INJURED

Check if Applicable:  Right  Left

Face  Eye  Nose  Ear  Mouth  Neck  Back  
 Shoulder  Torso  Arm  Hand  Finger  Wrist  Hip  
 Groin  Leg  Knee  Ankle  Foot  Toe  Other

DETAILS: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**IMMEDIATE ACTION TAKEN**

Name of First Responder \_\_\_\_\_  
Staff Position \_\_\_\_\_ Phone # \_\_\_\_\_

First Aid Rendered (Check All That Apply):  
 Kept Immobile     Elevated     Applied Ice     Stopped Bleeding  
 CPR     None Rendered     Wrapped Wound     Rescue Breathing  
 Other (Please Specify) \_\_\_\_\_  
 Victim Self Care     EMS Called

DESCRIBE IN GREATER DETAIL: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FURTHER CARE**

Went home on own     Self/Friend to Hospital     Ambulance to Hospital  
 Friend took home     Self/Friend to Health Center     Left Area, No Information

Witness \_\_\_\_\_ Phone \_\_\_\_\_ Address \_\_\_\_\_  
Witness \_\_\_\_\_ Phone \_\_\_\_\_ Address \_\_\_\_\_

Refusal of Service (Injured Signature) \_\_\_\_\_ Date \_\_\_\_\_

Signature of Person Completing Report \_\_\_\_\_ Date \_\_\_\_\_

**THIS REPORT MUST BE FILED WITH APPROPRIATE DIRECTOR WITHIN 24 HOURS OF ACCIDENT.**

**ACCIDENT REPORT FOLLOW-UP**

REPORT REVIEWED BY (PLEASE INITIAL): \_\_\_\_\_ Asst. Director    \_\_\_\_\_ Manager    Date Reviewed \_\_\_\_\_

**Follow-Up Report on Injured Person's Progress - Call Log:**

Attempt #1    Date \_\_\_\_\_    Time \_\_\_\_\_    Caller Signature \_\_\_\_\_  
Attempt #2    Date \_\_\_\_\_    Time \_\_\_\_\_    Caller Signature \_\_\_\_\_  
Attempt #3    Date \_\_\_\_\_    Time \_\_\_\_\_    Caller Signature \_\_\_\_\_

**STATUS OF INJURED PERSON:**

Injured participant is fine now. No complications.  
 The accident was serious enough to warrant additional medical attention. The injury was diagnosed as \_\_\_\_\_  
 Unknown

Submitted by \_\_\_\_\_ Date \_\_\_\_\_ Signature \_\_\_\_\_

Medical Care:  Hospital     EMS     Private Physician     None     Other

**FINAL REVIEW BY:** \_\_\_\_\_ Assistant Director    \_\_\_\_\_ Manager    Date \_\_\_\_\_