

Incident Report Form

Date of illness/incident: _____ Time: _____ AM/PM

Name of sick/injured/affected person: _____

Address: _____

Phone Number(s): _____

Date of birth: _____ Male _____ Female _____

Who was injured person? (circle one)

Student Adult Participant Leader/co-leader Staff Guide

Type of illness/injury/incident: _____

Details of illness/injury/incident: _____

Illness/injury/incident requires physician/hospital Yes _____ No _____

visit? Name of physician/hospital: _____

Address: _____

Physician/hospital phone number: _____

ISSUE IN DETAIL

What have you tried to do/done to resolve the issue (if applicable) and any other details you think are relevant.

Signature of person recording: _____

Date _____