ADELAIDE COMMUNITY BASKETBALL ASSOCIATION

Incident Report

Name and role of person completing this form:
Signature of person completing this form:
Date:

Incident

Date and time of incident:
Name/s of person/s involved in the incident and their clubs/associations:
Description of incident:

Witnesses (include contact details):

Reporting of the incident to club/association

Incident Reported to:	**Date:**
How (this form, in person, email, phone):	

Follow Up Action

Description of actions to be taken:

ADELAIDE COMMUNITY BASKETBALL ASSOCIATION

Injury details: This report reflects an accurate record of the injured person's reported symptoms of injury
COACH/MANAGER – Please retain a copy of this form. The original should be forwarded to the Norwood Office

Name of injured person:	Date of birth / / (Day month year)
Date when the injury occurred	Date when injury is evident
Person injured: ☐ Athlete ☐ Coach ☐ Other	Gender: ☐ M ☐ F
Supervising coach: _____ (Signature)	Witness:_____ (Signature)

First aid provided_____ (Signature)

Time of first aid

Initial treatment:

☐ No treatment required
☐ CPR ☐RICER
☐ Crutches ☐ Sling/splint
☐ Dressing ☐ Strapping
☐ Massage ☐ Stretching

Nature of injury: ☐ New injury ☐ Aggravated injury ☐ Recurrent injury ☐ Other

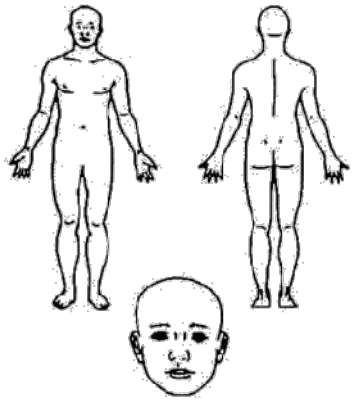
Did the injury occur during: ☐ Training ☐ Event ☐ Other:

Symptoms of injury:

☐ Blisters
☐ Inflammation/swelling
☐ Spinal injury ☐ Burn
☐ Graze/abrasion
☐ Concussion/head injury
☐ Insect bite/sting
☐ Cramp
☐ Cardiac problem
☐ Bruising/contusion
☐ Suspected bone fracture/break
☐ Electrical shock
☐ Cut
☐ Dislocation
☐ Sprain
☐ Loss of consciousness
☐ Poisoning
☐ Strain
☐ Respiratory problem
☐ Bleeding nose
☐ Other:

Body part injured:

right left left right



How did the injury occur?

☐ Collision with a fixed object
☐ Overbalance
☐ Collision/contact with another person
☐ Overstretch
☐ Fall from height/awkward landing
☐ Slip/trip
☐ Fall/stumble on same level
☐ Other – please give details:

Was protective equipment worn on the injured body part?

☐ Yes ☐ No

Follow up action: ☐ None ☐ Medical practitioner/physiotherapist ☐ Hospital ☐ Ambulance ☐ Other:

Signature of person completing form:
Date: / /20