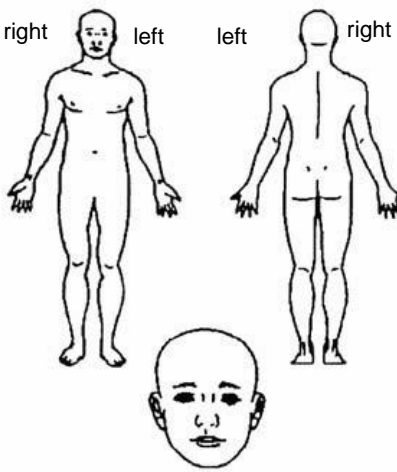


AHIGS - IGSSA INJURY REPORT FORM

Injury details: This report reflects an accurate record of the injured person's reported symptoms of injury

NAME OF PERSON INJURED		VENUE	
School attended by injured player		Venue Convener: (Print Name & Sign)	
Players' DOB (Day/Month/Year) / /		DATE INJURY OCCURRED / /	
Sport Being Played Team No & Grade		First Aid Provided By: (Print Name & Sign)	
Does the injured player currently play the same sport in another competition		<input type="checkbox"/> Yes <input type="checkbox"/> No Time of First Aid:	
Please indicate during WHICH EVENT the injury occurred		INITIAL TREATMENT	
<input type="checkbox"/> Saturday Sport <input type="checkbox"/> Rep Trials <input type="checkbox"/> Rep Matches / Comp <input type="checkbox"/> Sports Carnival <input type="checkbox"/> Warm Up <input type="checkbox"/> Competition <input type="checkbox"/> Event <input type="checkbox"/> Other			
NATURE OF INJURY		<input type="checkbox"/> No treatment required <input type="checkbox"/> CPR <input type="checkbox"/> RICER <input type="checkbox"/> Crutches <input type="checkbox"/> Sling / splint <input type="checkbox"/> Dressing <input type="checkbox"/> Strapping <input type="checkbox"/> Massage <input type="checkbox"/> Stretching	
<input type="checkbox"/> New Injury <input type="checkbox"/> Previous injury from other terms <input type="checkbox"/> Previously injured this term <input type="checkbox"/> Other (please explain)			
SYMPTOMS OF INJURY			
<input type="checkbox"/> Possible concussion - removed from play <input type="checkbox"/> Blisters <input type="checkbox"/> Inflammation / swelling <input type="checkbox"/> Spinal injury <input type="checkbox"/> Bleeding nose <input type="checkbox"/> Cramp <input type="checkbox"/> Cardiac problem <input type="checkbox"/> Bruising/contusion <input type="checkbox"/> Suspected bone fracture / break <input type="checkbox"/> Electrical shock <input type="checkbox"/> Cut <input type="checkbox"/> Dislocation <input type="checkbox"/> Burn <input type="checkbox"/> Graze / abrasion <input type="checkbox"/> Head injury <input type="checkbox"/> Insect bite / sting <input type="checkbox"/> Sprain <input type="checkbox"/> Loss of consciousness <input type="checkbox"/> Poisoning <input type="checkbox"/> Strain <input type="checkbox"/> Respiratory problem <input type="checkbox"/> Other:			
BODY PART INJURED (circle below)		HOW DID THE INJURY OCCUR	
Name of part		<input type="checkbox"/> Contact with a fixed object (e.g. wall, goal post)	
Location of injury		<input type="checkbox"/> Contact with another person <input type="checkbox"/> Overbalance <input type="checkbox"/> Contact with a ball or equipment (e.g. bat / stick) <input type="checkbox"/> Overstretch <input type="checkbox"/> Fall <input type="checkbox"/> Slip/trip <input type="checkbox"/> Other: <input type="checkbox"/> Running <input type="checkbox"/> <input type="checkbox"/> Sidestep <input type="checkbox"/> <input type="checkbox"/> Landing	
right left left right 		Extra detail regarding how the injury occurred:	
		Was protective equipment worn on the injured body part? <input type="checkbox"/> Yes <input type="checkbox"/> No	
FOLLOW UP ACTION		<input type="checkbox"/> None <input type="checkbox"/> Medical practitioner / physiotherapist <input type="checkbox"/> Hospital <input type="checkbox"/> Ambulance <input type="checkbox"/> Other:	
Signature of person completing form:		Date: / /	

Note: Staff without medical training should refer all medical decisions to appropriately qualified persons. Do not attempt to 'diagnose' an injury. Users of this form are advised that medical information should be treated confidentially.

Please ensure you contact IGSSA Director or Assistant Director of Sport ASAP if an ambulance is called