ACCIDENT/INCIDENT REPORT FORM

(Return one copy to Council Shop, one copy to the Director of Program Services and place original in program site files to be returned to staff advisor.)

Program Site: ________________________________ Date: ________________
Address: ___________________________________ Phone: ________________
Name of Person Involved: _____________________ Age: ________________

□ Participant  □ Staff  □ Volunteer (Adult)  □ Visitor

Name of Parent/Guardian (if minor): ________________________________
Address: ___________________________________ Phone: ________________
Number and Street  City  State  Zip

Name/Addresses/Phone of Witnesses (you may wish to attach signed statements)
1. ______________________________________________________________
2. ______________________________________________________________
3. ______________________________________________________________

Type of Incident  □ Behavioral  □ Accident  □ Other: ____________________

Date of Incident/Accident: ____________________________ Hour: ______________
Month  Day  Year  □ a.m.  □ p.m.

Describe the sequence of events in detail including what the person was doing: ________________________________
______________________________________________________________
______________________________________________________________

Where the incident occurred (specify location, including location of the person and witnesses. Use diagram to locate persons/objects): ________________________________

Was the person participating in an activity at the time of injury?  □ Yes  □ No
If yes, what activity? ______________________________________________

Any equipment involved in accident?  □ Yes  □ No  If yes, what kind: ____________________________

Emergency procedures followed at time of incident/accident: ________________________________
______________________________________________________________

By whom? ___________________________________________________________________________

(Continued on other side)
 Were parents notified? □ Yes □ No Date: _________________ Time: _______________ □ a.m. □ p.m.

 By whom? ___________________________________________ Title: _________________

 Parent’s Response? _______________________________________

 Where was treatment given? □ At accident site □ First Aid Center
 By whom? ___________________________________________ Date: _________________

 Treatment given: _______________________________________

 Was the injured retained overnight in First Aid Center? □ Yes □ No

 Additional treatment given: _________________________________
 By whom? ___________________________________________ Date: _________________

 Date released from health service: ___________________________

 Released to □ Program Activities □ Home □ Other: ___________________________

 Treatment given elsewhere than program site? □ Yes □ No Where? ___________________________
 By whom? ___________________________________________ Title: _________________

 Was the person kept overnight in the hospital? □ Yes □ No
 Which? ___________________________________________ Where? ___________________________

 Name of attending Physician: _______________________________
 Date of hospital release: _________________________________

 Released to □ Program Site □ Home □ Other: ___________________________

 Comments: _______________________________________

 Persons notified (Council Administrators):
 Name: ______________________________ Position: _____________ Date: _____________
 Name: ______________________________ Position: _____________ Date: _____________
 Name: ______________________________ Position: _____________ Date: _____________

 Describe any contact made with/by the media regarding this situation: _________________

 Submitted by: ______________________________ Date: _____________
 Position: ______________________________ Phone Number: ______________

 Insurance Notification (It is the intention of Girl Scouts of the USA to provide secondary accident insurance):
 1. □ Parent’s Insurance Date: _________________
 2. □ Council Insurance Date: _________________
 3. □ Workers Compensation Date: _________________

 9/27/2016