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)

Medical Report of Accident/Incident

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: ____________