



Injury Report

Boyertown Soccer Club

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|----------------------------------|--|
| Date of Incident: | Date of Report: |
| Time of Incident: | Team: |
| Person Completing Report: | Head Coach Name: |
| Player Name: | Parent/Guardian Name: |
| Affected Party: | <input type="checkbox"/> Player <input type="checkbox"/> Coach <input type="checkbox"/> Official <input type="checkbox"/> Spectator <input type="checkbox"/> Volunteer <input type="checkbox"/> Other |

| | | |
|---|---|--|
| BODY PART INJURED | ANKLE/KNEE INJURY: | PRIMARY INJURY |
| <input type="checkbox"/> Ankle (L/R) <input type="checkbox"/> Finger (L/R) <input type="checkbox"/> Nose <input type="checkbox"/> Foot (L/R) <input type="checkbox"/> Arm (L/R) <input type="checkbox"/> Hand <input type="checkbox"/> Shoulder (L/R) <input type="checkbox"/> Head <input type="checkbox"/> Back <input type="checkbox"/> Internal <input type="checkbox"/> Toe <input type="checkbox"/> Knee (L/R) <input type="checkbox"/> Ear (L/R) <input type="checkbox"/> Leg <input type="checkbox"/> Tooth <input type="checkbox"/> Neck <input type="checkbox"/> Eye (L/R) <input type="checkbox"/> Other <input type="checkbox"/> Wrist (L/R) | <input type="checkbox"/> Ankle Taped/Supported <input type="checkbox"/> Ankle Unsupported <input type="checkbox"/> Knee Taped/Supported <input type="checkbox"/> Knee Unsupported <input type="checkbox"/> Other | <input type="checkbox"/> Abrasion <input type="checkbox"/> Laceration <input type="checkbox"/> Burn <input type="checkbox"/> Nausea <input type="checkbox"/> Cardiac <input type="checkbox"/> Seizures <input type="checkbox"/> Concussion <input type="checkbox"/> Sting/Bite <input type="checkbox"/> Dislocation <input type="checkbox"/> Strain/Sprain <input type="checkbox"/> Fracture <input type="checkbox"/> Other <input type="checkbox"/> Heat Exhaustion |
| LOCATION | INCIDENT | DISPOSITION |
| <input type="checkbox"/> Before Match/Event <input type="checkbox"/> During Match/Event <input type="checkbox"/> After Match/Event <input type="checkbox"/> Bleachers/Stands <input type="checkbox"/> Concession Area <input type="checkbox"/> Off Property <input type="checkbox"/> Parking Lot <input type="checkbox"/> Restrooms | <input type="checkbox"/> Collision (Participant/Participant) <input type="checkbox"/> Collision (Participant/Spectator) <input type="checkbox"/> Collision (Spectator/Spectator) <input type="checkbox"/> Collision (with object) <input type="checkbox"/> Caught in, on, between goal <input type="checkbox"/> Struck by falling/flying object <input type="checkbox"/> Animal/insect bite/sting <input type="checkbox"/> Slip/Fall <input type="checkbox"/> Assault/Non-Sexual <input type="checkbox"/> Assault/Sexual <input type="checkbox"/> Other | No care given: <input type="checkbox"/> Not needed <input type="checkbox"/> Patient Refused Released: <input type="checkbox"/> To Parent/Guardian <input type="checkbox"/> EMT EMS Transport: <input type="checkbox"/> To Hospital/Clinic <input type="checkbox"/> Patient/Parent Requested |

| | |
|--|---|
| FIELD SURFACE | Classification |
| <input type="checkbox"/> Astro Turf <input type="checkbox"/> Dirt <input type="checkbox"/> Field Turf <input type="checkbox"/> Grass <input type="checkbox"/> Indoor | <input type="checkbox"/> Non-Injury (Threat, Assault) <input type="checkbox"/> Minor Injury or Illness <input type="checkbox"/> Serious Injury or Illness |



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Coach Comments: Describe how the injury occurred:

Players/Parents Comments: _____

Coach Signature: _____ **Parent/Guardian Signature:** _____

Player Signature: _____ **Date:** _____

BSC Authorized Signature: _____ **Date:** _____



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ADMINISTRATIVE ACTION: _____

BSC Authorized Signature: _____ Date: _____

