Thompson Rivers Parks & Recreation District
Accident/Incident Report Form

PRINT LEGIBLY

Date: ______________ Time: _______________ AM / PM Day: S M T W T F S

Name: ______________________________ Age:______ DOB:______ Sex: M F Height:______

Address: ____

Phone: _________________ Parents' Name (if under 18) _______________________________

Location of Accident/Incident: Facility: ____

Specific location within the facility: ____

Non-Employee Witnesses:

1. Name____ Phone_____________________

2. Name____ Phone_____________________

Nature of Injury (mark all that apply):

___Abrasion (scratch)
___Amputation
___Avulsion
___Puncture
___Fracture
___Sprain
___Cold Related
___Burn
___Previously existing
___Other _______________
___Laceration
___Contusion (bruise)
___Strain
___Concussion
___Heat Related
___Respiratory
___Allergy Related

Part of Body Injured:

___Head
___Eye
___Mouth
___Chin
___Elbow
___Hand
___Finger/Thumb
___Chest
___Leg
___Ankle
___Toe
___Ear
___Face
___Cheek
___Nose
___Neck
___Arm
___Wrist
___Back
___Thigh
___Knee
___Foot
___Shoulder

Exact location of injury: ____________________

____

(Left/right, front/back, etc.)

Description of Accident/Incident:

How/why did the accident happen? What was the patron doing? List contributing conditions, tools or acts that may have been seen as unsafe.

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Extent of Injury: _____ Mild _____ Moderate _____ Serious

Immediate Action Taken:

First Aid Treatment Provided:____

____ Given By:_____________________________

Blood Present? Y N Gloves Worn? Y N

AED Used? Y N By (Name)__________________________ # of Defibrillations:_____

Sent Home? Y N By (Name)____

Taken to Hospital? Y N By (Name)____

Responding Emergency Vehicle (circle all that apply): Police Fire Ambulance

From what hospital/station(s)? ____

Were Parents notified? Y N Present in Facility? Y N Contacted by phone? Y N

By (Name) ______________________________________

Was Full Time Supervisor notified? Y N By (Name) __________________________________

Name of Supervisor that was notified: ____

Leader in Charge of Facility at Time of Accident:

(Name and Position)____

Signed: Leader/Manager______________________________ Date: _____________

Supervisor___________________________________ Date: _____________

Division Director_____________________________ Date: _____________

This report MUST be sent to the Parks & Recreation office within 24 hours after the accident!!!

320 Centennial Dr Milliken, CO 80543

Monday – Friday, 8 a.m. - 5 p.m.

For Office Use Only:

E-mailed to Human Resources: ____

By: ____

Time: _________________________________ Date: ________________________________