SPECIAL OLYMPICS MICHIGAN
FIRST REPORT OF ACCIDENT / INCIDENT

Date of Incident: _____ **Area**____
Injured Person/Party Information Date of Birth: ____/_____/_____Age: _____

Name: _____
(Last) (First) (MI)

Address: _____
(Street) (City) (State) (Zip)

Home Phone: (_____)_____-_____ Work Phone: (_____)_____-_____

Gender: ☐ Male ☐ Female

Type of Injury/ Accident:
☐ Bodily Injury
☐ Property Damage
☐ Automobile
☐ Other:

Injured Party:
☐ Athlete
☐ Volunteer
☐ Coach
☐ Employee
☐ Spectator
☐ Unified Partner
☐ Property Owner
☐ Other: _____

Description of Accident (If automobile accident occurred, please attach a copy of the police report).

Describe how the accident occurred (Attach a separate sheet if necessary): _____
_____

_____

_____

Site / event where accident occurred:_____

Accident Occurred During:
☐ Training/Practice
☐ Competition
☐ Traveling to or from SO event
☐ Other: _____

Type of Injury:
☐ Severe cut w/ bleeding
☐ Less serious bruise or cut
☐ Break/fracture
☐ Concussion
☐ Paralysis
☐ Fatality
☐ Other: _____

Disposition:
☐ Released to parent
☐ Refusal of care
☐ Refer to doctor
☐ Refer to hospital or clinic
☐ Medical attention
☐ EMS transport
☐ Patient requested EMS transport
☐ Released to personal vehicle
☐ Police
☐ Ambulance
☐ Report only
☐ Other:

Sport
☐ Alpine Skiing
☐ Aquatics
☐ Athletics
☐ Basketball
☐ Bocce
☐ Bowling
☐ Cross Country Ski
☐ Cycling
☐ Figure Skating
☐ Floor Hockey
☐ Golf
☐ Power Lifting
☐ Relay Game
☐ Snowboarding
☐ Snowshoe
☐ Soccer
☐ Softball
☐ Speed Skating
☐ Swimming
☐ Team Handball
☐ Track & Field
☐ Volleyball
☐ Other:

Body Part Injured:
☐ Head ☐ Neck
☐ Torso ☐ Back
☐ Hand (L / R)
☐ Finger (L / R)
☐ Elbow (L / R)
☐ Shoulder (L / R)
☐ Leg (L / R)
☐ Knee (L / R)
☐ Thigh (L / R)
☐ Shin (L / R)
☐ Toe (L / R)
☐ Other: _____

Contact/Care Provider Information If an athlete or underage volunteer was injured, please identify the care provider and/or responsible party (e.g. parent, legal guardian).

Relationship to the injured person: _____
Name: _____
Address: _____
_____
Home Phone: (_____)_____-_____

Employer Name: _____
Employer Address: _____
_____
Work Phone: (_____)_____-_____

Does the injured person have medical insurance? ☐ Yes ☐ No If yes, insurance is provided by: ☐ Injured Person ☐ Care Provider/Responsible Party

Please provide name of Company and Policy Number: _____

Witness Information (Please provide names and phone numbers of any witnesses to the incident)

Witness #1 Name: _____ Daytime Phone: (_____)_____-_____
Witness #2 Name: _____ Daytime Phone: (_____)_____-_____

Special Olympics Official / Representative (other than claimant)

Name: _____ Daytime Phone: (_____)_____-_____
Signature: _____

See Reverse Side

MEDICAL ROOM TREATMENT

History and Description of the Injury/Illness *(Who, What, Where, When, Why, How)*_____
_____

Subjective *(Signs & Symptoms from Victim, Coach or Responsible Party)*:_____
_____

Objective *(Physical findings*:_____
_____
_

Assessment *(Diagnosis/Impression)*:_____
_____
_

Treatment Delivered: _____
_____

Further Treatment Advised: _____
_____

Were further treatment instruction forwarded to another site or institution? ☐ Yes ☐ No

Medic completing this form: _____ Signature: _____

Supervising Physician Signature: _____ Case Review: ☐ Yes ☐ No

Special Olympics Official / Representative (other than claimant)
Name: _____ Daytime Phone: (_____)_____-_____
Signature: _____

FAX COMPLETED FORM TO: Special Olympics Michigan, (989) 774-3034
SEND COMPLETED FORM TO: Special Olympics Michigan, Central Michigan University, Mount Pleasant, MI 48859
If fatality or serious injury: Notify ASIS immediately: 1-800-566-7941 (24 HRS. A DAY/7 DAYS A WEEK), as well as SOMI State Office, 1-800-644-6404

Special Olympics Michigan

CONCUSSION EVALUATION AND RELEASE TO PLAY FORM

(SECTION ONE: Completed by Medical Personnel at Event)

Athlete Name: _____Date: _____

Sport: _____Area: _____Number of Past Concussions: _____

Brief Description on How Injury Occurred and Why Concussion is Suspected:

_____

(SECTION TWO: Completed by Licensed Health Care Provider after Event)

Per Michigan Public Act 343/343, an individual who is suspected of suffering a concussion may not return to play until the individual has been evaluated by a **licensed health care provider trained in the evaluation and management of concussions and head injuries**, receives a written clearance to return to play from the health care provider who evaluated the individual, **and not less than twenty-four (24) hours have passed since the individual was removed from play.**

Health Care Provider Name: _____

I have evaluated the above mentioned athlete and the athlete is:

_____**NOT** cleared to participate in any sports-related activities until seen for a follow-up exam

_____Cleared, as of today, to return to all activities, including sports, without restrictions

_____Cleared to return to sports following the schedule below:

Step 1: May participate in light activity on the following date* - _____
(10 minutes on an exercise bike, walking, or light jogging; but no weight lighting, jumping or hard running)
Step 2: May participate in moderate activity on the following date* - _____
(Moderate intensity activity on an exercise bike, jogging or weight lifting {reduced time and/or weight than normal})
Step 3: May participate in heavy; non-contact physical activity on the following date* -_____
(Sprinting, running, high-intensity exercise bike, and weight lifting; but no contact sports)
Step 4: May return to practice and full contact in a controlled practice setting on the following date* - _____
Step 5: May return to full game play on the following date* - _____

* Please note that if signs and symptoms of a concussion occur, the athlete must return to the previous stage and parents must contact the licensed health care provider for instructions.

_____ _____

(Signature of Health Care Provider) (Date)

Return completed form to your Area Director and:
Special Olympics Michigan
Central Michigan University
Mount Pleasant, MI 48859
Fax: 989-774-3034

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