



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



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 lifting, 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