



AMERICAN SPECIALTY™

### AASA FIRST REPORT OF ACCIDENT

|  |   |
|--|---|
| DATE OF INCIDENT _____ TIME OF INCIDENT _____ AM/PM<br>Name of Team/Club/Organization: _____<br>Address: _____<br>Telephone Number: _____  | <b>DOES THE INJURED PERSON HAVE OTHER MEDICAL INSURANCE?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO<br>If yes, please provide name of company and policy #: _____   |
| <b>INJURED PERSON:</b> <input type="checkbox"/> Athlete <input type="checkbox"/> Official <input type="checkbox"/> Coach<br><input type="checkbox"/> Spectator <input type="checkbox"/> Employee <input type="checkbox"/> Volunteer <input type="checkbox"/> Other _____ | <b>DID THIS TAKE PLACE DURING:</b><br><input type="checkbox"/> Practice <input type="checkbox"/> Competition <input type="checkbox"/> Club activity<br><input type="checkbox"/> Pre-activity <input type="checkbox"/> Sanctioned event <input type="checkbox"/> During activity<br><input type="checkbox"/> After activity <input type="checkbox"/> While traveling |

#### INJURED PERSON INFORMATION

|                      |        |        |   |  |
|----------------------|--------|--------|---|--|
| Last Name            | First  | Middle | Telephone Number (    )                                       | <input type="checkbox"/> Single <input type="checkbox"/> Married |
| Address              |        |        | Social Security Number  |  |
| City                 |        | State  | Zip   |  |
| Age                  | D.O.B. |        | <input type="checkbox"/> Male <input type="checkbox"/> Female |  |
| Employer and Address |        |        |   |  |

#### GUARDIAN/PARENT (IF INJURED PERSON IS A MINOR)

|           |       |        |                         |
|-----------|-------|--------|-------------------------|
| Last Name | First | Middle | Telephone Number (    ) |
| Address   |       | City   | State      Zip          |

|  |  |  |
|--|--|--|
| <b>SPORT</b><br><input type="checkbox"/> Martial Arts<br><input type="checkbox"/> Paintball<br><input type="checkbox"/> Baseball<br><input type="checkbox"/> Gymnastics<br><input type="checkbox"/> Football<br><input type="checkbox"/> Volleyball<br><input type="checkbox"/> Basketball<br><input type="checkbox"/> Other _____   | <b>INCIDENT LOCATION</b><br><input type="checkbox"/> Competition area <input type="checkbox"/> Concession area<br><input type="checkbox"/> Parking lot <input type="checkbox"/> Admission area<br><input type="checkbox"/> Restrooms/locker rooms <input type="checkbox"/> Off property<br><input type="checkbox"/> Premises/grounds <input type="checkbox"/> Store area<br><input type="checkbox"/> Bleachers/stands<br><br><b>CLASSIFICATION</b><br><input type="checkbox"/> Non-injury<br><input type="checkbox"/> Minor injury or illness<br><input type="checkbox"/> Serious injury or illness  | <b>INCIDENT</b><br><input type="checkbox"/> Assault/Sexual <input type="checkbox"/> Slip, bodily reaction<br><input type="checkbox"/> Assault/Non-Sexual <input type="checkbox"/> Slip/Fall<br><input type="checkbox"/> Fall (different level)<br><input type="checkbox"/> Fall (same level) <input type="checkbox"/> Aquatic<br><input type="checkbox"/> Caught in, on, between <input type="checkbox"/> Trip/Fall<br><input type="checkbox"/> Animal/insect bite/sting<br><input type="checkbox"/> Collision (with object) <input type="checkbox"/> Overexertion<br><input type="checkbox"/> Collision (participant/participant)<br><input type="checkbox"/> Collision (participant/spectator)<br><input type="checkbox"/> Collision (spectator/spectator)<br><input type="checkbox"/> Struck by falling/flying object |
| <b>PRIMARY INJURY</b><br><input type="checkbox"/> Allergy <input type="checkbox"/> Dislocation <input type="checkbox"/> Nausea<br><input type="checkbox"/> Amputation <input type="checkbox"/> Electrical Shock <input type="checkbox"/> Stroke<br><input type="checkbox"/> Abrasion <input type="checkbox"/> Foreign Body <input type="checkbox"/> Burn<br><input type="checkbox"/> Laceration <input type="checkbox"/> Fracture <input type="checkbox"/> Death<br><input type="checkbox"/> Drowning <input type="checkbox"/> Heat Exhaustion <input type="checkbox"/> Pain<br><input type="checkbox"/> Hypertension <input type="checkbox"/> Cardiac <input type="checkbox"/> Illness<br><input type="checkbox"/> Cold Injury <input type="checkbox"/> Contusion <input type="checkbox"/> Sting/bite<br><input type="checkbox"/> Seizures <input type="checkbox"/> Concussion<br><input type="checkbox"/> Strain/Sprain <input type="checkbox"/> Tooth/Mouth | <b>BODY PART INJURED</b><br><input type="checkbox"/> Eye (L/R) <input type="checkbox"/> Torso <input type="checkbox"/> Arm (L/R)<br><input type="checkbox"/> Nose <input type="checkbox"/> Back <input type="checkbox"/> Tooth<br><input type="checkbox"/> Neck <input type="checkbox"/> Face <input type="checkbox"/> Head<br><input type="checkbox"/> Ear (L/R) <input type="checkbox"/> Leg (L/R)<br><input type="checkbox"/> Knee (L/R) <input type="checkbox"/> Ankle (L/R)<br><input type="checkbox"/> Internal <input type="checkbox"/> Hip (L/R)<br><input type="checkbox"/> Shoulder (L/R) <input type="checkbox"/> Foot (L/R)<br><input type="checkbox"/> Elbow (L/R) <input type="checkbox"/> Hand (L/R)<br><input type="checkbox"/> Wrist (L/R) <input type="checkbox"/> Finger or Toe | <b>DISPOSITION</b><br><input type="checkbox"/> Released to parent <input type="checkbox"/> Police<br><input type="checkbox"/> Refusal of care <input type="checkbox"/> Ambulance<br><input type="checkbox"/> Refer to doctor <input type="checkbox"/> Report only<br><input type="checkbox"/> Refer to hospital or clinic<br><input type="checkbox"/> Medical attention<br><input type="checkbox"/> EMS transport<br><input type="checkbox"/> Patient requested EMS transport<br><input type="checkbox"/> Released to personal vehicle   |

**Describe how the incident occurred: (attach a separate sheet if necessary)**

#### WITNESS INFORMATION

| NAME | ADDRESS | TELEPHONE NUMBER |
|------|---------|------------------|
| 1.   |         | (    )           |
| 2.   |         | (    )           |

Signature of Coach or Official (with no relationship to claimant) \_\_\_\_\_ DATE \_\_\_\_\_ Phone # \_\_\_\_\_