

Northeastern University Club Sports Program Injury Report



PLEASE PRINT CLEARLY IN INK

Sport _____ Event _____ Current School Attending _____

Date _____		Time _____		<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	ID/Social Security Number _____	
Last Name _____			First Name _____			<input type="checkbox"/> Male <input type="checkbox"/> Female
Address _____						
Street _____			City _____		Zip code _____	
Home Phone (____) _____			Birth Date ____/____/____			
Status: <input type="checkbox"/> Student <input type="checkbox"/> Alumni <input type="checkbox"/> Faculty <input type="checkbox"/> Staff <input type="checkbox"/> Spouse <input type="checkbox"/> Other						

1. Possible Type of Injury (specify if other): _____
- Blister Contusion Fracture Puncture Strain
 Concussion Dislocation Laceration Sprain Other (specify) _____

2. Body Part Injured: Right Left
- | | | | | | | |
|--------------------------------------|----------------------------------|-----------------------------------|-------------------------------------|---------------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Ankle | <input type="checkbox"/> Ear | <input type="checkbox"/> Forearm | <input type="checkbox"/> Hip | <input type="checkbox"/> Nose | <input type="checkbox"/> Stomach | <input type="checkbox"/> Triceps |
| <input type="checkbox"/> Biceps | <input type="checkbox"/> Elbow | <input type="checkbox"/> Forehead | <input type="checkbox"/> Jaw | <input type="checkbox"/> Palm of Hand | <input type="checkbox"/> Tailbone | <input type="checkbox"/> Upper Back |
| <input type="checkbox"/> Buttocks | <input type="checkbox"/> Eye | <input type="checkbox"/> Groin | <input type="checkbox"/> Knee | <input type="checkbox"/> Ribs | <input type="checkbox"/> Thigh (hamstring) | <input type="checkbox"/> Wrist |
| <input type="checkbox"/> Calf | <input type="checkbox"/> Eyebrow | <input type="checkbox"/> Hand | <input type="checkbox"/> Lower Back | <input type="checkbox"/> Shin | <input type="checkbox"/> Thigh (quadriceps) | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Chest | <input type="checkbox"/> Finger | <input type="checkbox"/> Head | <input type="checkbox"/> Mouth | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Throat | |
| <input type="checkbox"/> Collar Bone | <input type="checkbox"/> Foot | <input type="checkbox"/> Heel | <input type="checkbox"/> Neck | <input type="checkbox"/> Sternum | <input type="checkbox"/> Toe | |

3. Specific description of how the injury occurred: _____

4. What care was provided and what action was taken for the injured person? (Be Specific) _____

5. Facility where Injury Occurred:
- | | | | | | |
|---|--|--|--------------------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> Marino BB Courts | <input type="checkbox"/> Cabot Pool | <input type="checkbox"/> Parsons Field | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Marino Studio A | <input type="checkbox"/> Madison Park | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Marino Studio B | <input type="checkbox"/> Carter Playground | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Cabot Cage | <input type="checkbox"/> Matthews Arena | <input type="checkbox"/> | <input type="checkbox"/> Other _____ | | |

6. Specific Area/Equipment where Injury Occurred: (Specify exact name) _____
7. Was participant advised to seek further medical treatment? Yes No
8. Was participant advised to discontinue participation? Yes No
9. Did participant continue to participate? Yes No
10. Was Public Safety Notified? Yes No

Name of responding officer: _____

11. Participant left the facility by: Self With Friends Ambulance University Police Other (specify) _____

Print Name of Person Filing Report: _____	Signature: _____
Witness Name: _____	Witness Phone Number: _____
Signature of Injured: _____	Date: _____

Approval: _____ Entered: _____

Please Fax To: Jerry Foster, 617-373-8278 and Omar Rouhana, 617-373-5000 within two business days.