



DSL Soccer Accident Report Form

Date of Accident _____

Name of Injured: _____ Male _____ Female _____

Age of Injured: _____

Address of Injured: _____

Telephone Number _____

Date of Accident: _____

Time of Accident: _____ A.M / P.M.

Location Accident Occurred: _____

Nature of Injury

Ankle _____

Finger _____

Foot _____

Forearm _____

Head _____

Scalp _____

Tooth _____

Wrist _____

Face _____

Mouth _____

Nose _____

Hand _____

Ear _____

Knee _____

Elbow _____

Other _____

Leg _____

Arm _____

Back _____

Shoulder _____

Eye _____

Thigh _____

Ribs _____

Probable Cause of Accident

Fall _____ Collision _____ Struck by _____ Specify Other _____

Brief Description of Accident: _____

Immediate Action Taken

First Aid _____
Sent to Hospital _____
Sent to Doctor _____
Other _____

Emergency Number Available _____
First Aid Kit on Site _____
Refused Attention _____

Method of Transportation

Time Reported

Time Arrived

Ambulance _____	_____	_____
Private Vehicle _____	_____	_____
Law Enforcement _____	_____	_____
Fire Dept. Res. Squad _____	_____	_____
Other _____	_____	_____

Information of Witnesses

Name _____
Address _____
Phone _____

Name _____
Address _____
Phone _____

Notified League Coordinator

Rob Glentzer 412-491-9377 Yes / No Date _____ Time _____ A.M. / P.M.

Person Completing Report

Name _____
Address _____
Phone _____
Position _____ Date _____

Signature _____

League Coordinator

Signature _____
Date _____

Follow Up Recommended: Yes _____ No _____