Sports Injury Report Form
Little Athletics Victoria

Inured Person Details

NAME

DATE OF BIRTH - - GENDER

ADDRESS

SUBURB STATE POSTCODE

PHONE

MOBILE

KNOWN ALLERGIES/MEDICAL CONDITIONS/MEDICATIONS

Parent/Guardian Details

NAME

ADDRESS

SUBURB STATE POSTCODE

PHONE

MOBILE

Incident Details

CENTRE/CLUB STATE

DATE TIME

VENUE

EVENT (I.E. HIGH JUMP, HURDLES ETC.)

INCIDENT (PLEASE PROVIDE BRIEF OUTLINE OF WHAT OCCURRED)

IS ANYONE RESPONSIBLE FOR THE INJURY (IF YES, PLEASE PROVIDE DETAILS)

(03) 8646 4510
www.lavic.com.au

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Initial Assessment

RESPONSIVE	Yes		No	
CLEAR AIRWAY	Yes		No	
BREATHING	Yes		No	
PULSE	Yes		No	
BLEEDING	Yes		No	

INJURY TO (PART OF THE BODY)

REMOVAL FROM SITE (WALK, CARRY, AMBULANCE)

First Aid Treatment Provided

OUTLINE

FINAL ASSESSMENT (DID THE PERSON RETURN TO COMPETITION) Yes No

ACTION TAKEN (IF REQUIRED & INCLUDE IF IT WAS PREVENTABLE)

FIRST AID PERSON (NAME)

WITNESS (NAME) PHONE

NAME OF CENTRE SIGNATORY SIGNATURE

TITLE DATE

CLAIM FORM (WAS A PERSONAL ACCIDENT CLAIM FORM PROVIDED) Yes No