

## ACCIDENT REPORT

Sports Clubs 2009 - 2010

### PERSONAL DATA – to be filled out by Club Officer

Name of Injured \_\_\_\_\_

Local Address \_\_\_\_\_

Check this box if this person lives on campus

Local Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Gender:  Male  Female Age \_\_\_\_\_ D.O.B \_\_\_\_/\_\_\_\_/\_\_\_\_

Status of Injured:  Student  Faculty  Staff  Spouse  Other (Please Specify) \_\_\_\_\_

If under 18, name and phone number of parent or legal guardian: \_\_\_\_\_

### DETAILS OF ACCIDENT – to be filled out by Club Officer

Date of Accident \_\_\_\_/\_\_\_\_/\_\_\_\_ Time of Accident \_\_\_\_\_ Time of Treatment \_\_\_\_\_ Time of Report \_\_\_\_\_

Club Officer Responding \_\_\_\_\_ Position \_\_\_\_\_ Phone \_\_\_\_\_

Location of Accident:

Strom WFC Building  Blatt P.E. Center  Blatt P.E.C. Fields  Strom WFC Fields  Other \_\_\_\_\_

Sport and Specific Location of Accident (Ex. Rugby – Blatt fields): \_\_\_\_\_

### HOW DID INJURY OCCUR – to be filled out by Club Officer

Collision w/obstacle  Collision w/participant  Collision w/playing surface

Equipment Related  Non-Contact  Unknown

Other (please specify): \_\_\_\_\_

Describe Specifically: \_\_\_\_\_

### PART OF BODY INJURED – to be filled out by Athletic Trainer or primary care giver

Describe Specifically: \_\_\_\_\_

### IMMEDIATE ACTION TAKEN – to be filled out by Athletic Trainer or primary care giver

Name of Athletic Trainer or primary care giver \_\_\_\_\_ Position \_\_\_\_\_ Phone \_\_\_\_\_

First Aid Rendered (Describe in great detail): \_\_\_\_\_

### FURTHER CARE – to be filled out by Athletic Trainer of primary care giver

Returned to game

Went home on own

Friend took home

Self/friend to hospital

Self/friend to Thompson Health Center

Ambulance to hospital

Left area, no information  Refused Transport

COMMENTS (incl. which hospital if transported): \_\_\_\_\_

**\*\*IF 911 IS CALLED, AARON (803.760.6561) MUST BE NOTIFIED IMMEDIATELY\*\***

**EMERGENCY MEDICAL SERVICES  
ELECTION FORM  
UNIVERSITY OF SOUTH CAROLINA  
COLUMBIA, SC 29208**

Date: \_\_\_\_\_ Location: \_\_\_\_\_

Time: \_\_\_\_\_ USC Club Member's Name: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Last 4 digits of SSN: \_\_\_\_\_

Check which Applies: Injury: \_\_\_ Illness: \_\_\_

Nature of Injury/Illness: \_\_\_\_\_  
\_\_\_\_\_

Is there an obvious or serious Injury? Yes: \_\_\_ No: \_\_\_ (if yes, call 7-9111 immediately)

Is the patient conscious? Yes: \_\_\_ No: \_\_\_ Ambulatory? Yes \_\_\_ No: \_\_\_ (if no, call 7-9111 immediately)

If there is no reason to call 7-9111, advise the patient as follows and initial:

\_\_\_ The Student health Center is closed and will re-open at: 8am (M-F) or 4pm (Sun – emergency only)

\_\_\_ If you so desire and are able, you may provide your own transportation to a local hospital emergency room at this time.

\_\_\_ If immediate medical treatment is desired, an EMS ambulance will be called. EMS will transport all patients to a local hospital emergency room for treatment.

\_\_\_ There are charges for both EMS and/or emergency room services. The patient may be responsible for payment of and charges which exceed their health insurance coverage limits.

**\*\*Ask the patient if they desire EMS to be contacted. Have the patient complete the Patient Election section of the EMS Election form and comply with the patient's request.\*\***

Patient Election: I have been advised of options concerning medical care for my injury or illness and make the following election: (initial/sign below).

\_\_\_ I request that Emergency Medical Services be summoned to provide me medical assistance. I understand I may be transported to a local hospital emergency room for treatment. I will assume responsibility for any charges associated with this request which exceed my health insurance coverage limits.

\_\_\_ I do not wish Emergency Medical Services to be contacted to provide medical assistance or to provide transportation to a local hospital emergency room. I release the University of South Carolina and its employee's from any liability arising out of my decision not to summon EMS to provide medical assistance or transportation or out of the University's failure to summon EMS to provide medical assistance or transportation in connection with the injury or illness reported above.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Witness Name (printed)

\_\_\_\_\_  
Witness Phone Number

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