



Vacaville Christian Schools

ATHLETIC INJURY REPORT

Director of Athletics: Donna Hagans Athletics Office: (707) 446-1776 Ext. 5550

Student Name: _____ School: _____ Grade: _____

Sport/Activity: _____ Date & Time of Injury: ___/___/___ a.m. / p.m.

Parent/Guardian Contacted: _____ Phone # _____

Location of Injury: () Classroom () Field () Gym () Locker Room Activity: () Game () Practice () Other: _____

Area of Bodily Injury (check all that apply): Specify Side of Body: Right or Left

() Head () Neck () Spine/Back () Face () Ear () Nose () Eye () Mouth () Shoulder/Upper Arm () Elbow

() Lower Arm () Wrist () Hand () Chest () Abdomen () Hip () Groin () Upper Leg () Knee () Lower Leg

() Ankle () Foot

Type of Injury (check all that apply):

() Abrasion () Bite () Bruise () Burn () Cold Related () Concussion () Dislocation () Fracture

() Heat Related () Laceration () Puncture () Other: _____

First Aid Given (check all that apply):

() Iced Area () Washed Wound () Applied Dressing/Bandage

() Immobilized () Applied Pressure to Stop Bleeding () Other: _____

Action Taken: () Returned to Sport () Called Parent/Guardian () Parent/Guardian Took Athlete

() Transported to ER () Parent/Guardian Took to ER () Called 911 () Other: _____

Brief Explanation of Injury (use backside of page if more space is needed):

Witness Name: _____ Phone # _____

Submitted by: _____ Phone # _____