



Incident Report Form

DETAILS OF PERSON AFFECTED / INJURED	
Name:	
Address line 1:	
Address line 2:	
Post Code:	State:
Date of birth:	Phone number:
Email address:	
Occupation:	
DETAILS OF PERSON MAKING REPORT	
Name:	
Phone number:	
INCIDENT DETAILS	
Activity engaged in at time of incident:	
Type of incident: <input type="checkbox"/> Injury <input type="checkbox"/> Illness <input type="checkbox"/> Damage to property <input type="checkbox"/> Other	
Date of incident:	Time of incident:
Location of incident:	
Outcome of incident: <input type="checkbox"/> NIL injury / damage <input type="checkbox"/> Property damage <input type="checkbox"/> First aid administered By who: <input type="checkbox"/> Onsite medical treatment <input type="checkbox"/> Treatment by doctor <input type="checkbox"/> Hospital inpatient <input type="checkbox"/> Ambulance attended <input type="checkbox"/> Police attended	
Events leading up to incident (please include all actions, treatment and communication that took place):	
Possible cause events / triggers:	



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Related existing condition:

Equipment damaged: Yes No

If yes, describe extent of equipment damage:

Other people involved in incident:

Witness/es of incident:

Sequences of event following incident (details actions in chronological order up to the date of completion of report):

Additional follow up / actions / corrective measures:

The above report is accurate and corrective measures have been undertaken as necessary

Head Coach / Witness: Agree Disagree

Comments / further details:

Team Nurse: Agree Disagree

Comments / further details:

Assistant / Head of Delegation: Agree Disagree

Comments / further details:

HOD / AHOD Signature:

Date: