COLUMBIA UNIVERSITY
CLUB SPORTS

INJURY / ACCIDENT REPORT

Date of Accident (MM/DD/YYYY)	Time of Accident ❑ AM ❑ PM	EMT called? ❑ Yes ❑ No	Transported to a clinic or hospital? ❑ Yes ❑ No
NAME Last	First	Middle Initial	Date of Birth (MM/DD/YYYY)
HOME ADDRESS			Age
City	State	Zip Code	Phone Number
Sex ❑ Male ❑ Female	Affiliation (Check one) ❑ Student ❑ Faculty ❑ Staff ❑ Alumni ❑ Affiliate ❑ Guest		CU ID#:

Suspected Nature of Injury / Illness / Accident

	Abrasion		Convulsion		Heart		Poisoning		Suffocation
	Amputation		Cramps		Heat Exhaustion		Puncture		Other:
	Bleeding		Dislocation		Heat Stroke		Scratches		
	Burn / Scald		Fainting		Inhalation / Fumes		Shock		
	Contusion		Fracture		Internal Injury		Sprain		
	Concussion		Frostbite		Laceration		Strain		

Part of Body Injured

	Skull / Scalp		Jaw		Back		Wrist		Lower Leg
	Eye		Neck		Pelvis		Hand		Ankle
	Ear		Spine		Shoulder		Finger		Foot
	Nose		Chest		Upper Arm		Hip		Toe
	Mouth		Lungs		Elbow		Thigh		Other:
	Tooth		Abdomen		Forearm		Knee		

Exact Location of accident / incident:

Describe the activity the injured / ill person was engaged in at the time of the accident / incident (explain in detail):

Treatment (Check all that apply): ❑ Applied Ice ❑ Stopped Bleeding ❑ Immobilized ❑ Elevated

Was First Aid Administered? ❑ Yes ❑ No

Was injured / ill person taken to hospital? ❑ Yes ❑ No

Did the injured / ill person refuse medical treatment? ❑ Yes ❑ No

Transported by: ______________________________

If Yes, injured / ill person's signature acknowledging refusal of care: ______________________________

WITNESS: NAME:	PHONE:	E-MAIL:
REPORTED BY: NAME:	PHONE:	E-MAIL:
REVIEWED BY: NAME:	PHONE:	E-MAIL: