HIGH SCHOOL OFFICIALS FIRST REPORT OF ACCIDENT

AMERICAN SPECIALTY INSURANCE & RISK SERVICES, INC.
ATTN: CLAIMS DEPARTMENT
POST OFFICE BOX 459
ROANOKE, IN 46783
PHONE: 800-566-7941 FAX: 260-673-1291

DATE OF INCIDENT____________________________________
TIME OF INCIDENT______________________ ☐AM ☐PM

NAME OF TEAM/CLUB/ORGANIZATION:

____

Address:____

Telephone Number:____

DOES THE INJURED PERSON HAVE OTHER MEDICAL INSURANCE? ☐ YES ☐ NO
If yes, please provide name of company and policy #:

Company: ____

Policy #:____

DID THIS TAKE PLACE DURING:
☐Practice ☐Competition ☐Club Activity ☐Sanctioned Event
☐Pre-Activity ☐During Activity ☐After Activity
☐While Traveling

INJURED PERSON INFORMATION

Last Name	First	Middle	Telephone Number ( )	☐ Single ☐ Married
Address			Social Security Number________________________	
City	State	Zip	Employer ________________________	
Age	D.O.B.	☐ Male ☐ Female	Address________________________	

GUARDIAN/PARENT (IF INJURED PERSON IS A MINOR)

Last Name	First	Middle	Telephone Number ( )	
Address	City		State	Zip

SPORT	INCIDENT	PRIMARY INJURY
☐Wrestling ☐Soccer ☐Baseball ☐Gymnastics ☐Football ☐Volleyball ☐Basketball ☐Other	☐Assault/Sexual ☐Assault/Non-Sexual ☐Fall (different level) ☐Fall (same level) ☐Caught in, on, between ☐Collision (with object) ☐Collision (participant/participant) ☐Collision (participant/spectator) ☐Collision (spectator/spectator) ☐Struck by falling/flying object ☐ Slip, bodily reaction ☐ Slip/Fall ☐ Aquatic ☐ Overexertion ☐ Animal/insect bite/sting	☐ Allergy ☐ Amputation ☐ Abrasion ☐ Laceration ☐ Drowning ☐ Hypertension ☐ Cold Injury ☐ Seizures ☐ Strain/Sprain ☐ Dislocation ☐ Electrical Shock ☐ Foreign Body ☐ Fracture ☐ Heat Exhaustion ☐ Cardiac ☐ Contusion ☐ Concussion ☐ Tooth/Mouth ☐ Nausea ☐ Stroke ☐ Burn ☐ Death ☐ Pain ☐ Illness ☐ Sting/bite

BODY PART INJURED	DISPOSITION	INCIDENT LOCATION
☐ Eye (L/R) ☐ Nose ☐ Neck ☐ Ear (L/R) ☐ Knee (L/R) ☐ Internal ☐ Shoulder (L/R) ☐ Elbow (L/R) ☐ Wrist (L/R) ☐ Torso ☐ Back ☐ Face ☐ Leg (L/R) ☐ Ankle (L/R) ☐ Hip (L/R) ☐ Foot (L/R) ☐ Hand (L/R) ☐ Finger or Toe ☐ Arm (L/R) ☐ Tooth ☐ Head	☐ Released to parent ☐ Refusal of care ☐ Refer to doctor ☐ Refer to hospital or clinic ☐ Medical attention ☐ EMS transport ☐ Patient requested EMS transport ☐ Released to personal vehicle ☐ Police ☐ Ambulance ☐ Report only	☐ Competition area ☐ Parking lot ☐ Restrooms/locker rooms ☐ Premises/grounds ☐ Bleachers/stands ☐ Concession area ☐ Admission area ☐ Off property ☐ Store area **CLASSIFICATION** ☐ Non-injury ☐ Minor injury or illness ☐ Serious injury or illness

Describe how the incident occurred: ***(attach a separate sheet if necessary)***

WITNESS INFORMATION

NAME	ADDRESS	TELEPHONE NUMBER
1.		( )
2.		( )

SIGNATURE OF OFFICIAL____

PHONE # ______________________________ DATE______________________________