Washington State University
University Recreation

Incident Report

Individual Involved Information

Name (First and Last):	WSU ID Number (if applicable):	Phone Number:	Date of Birth: ___/___/___
☐ Male ☐ Female ☐ Other	☐ Student ☐ Non-Student	☐ Participant ☐ Volunteer ☐ Spectator ☐ Employee ☐ Youth	

General Accident/Incident Information

Facility Location (Example: SRC "Court Number"):

Date: ____/____/____

Time:_____ AM/PM

Program Area: ☐ Aquatics ☐ Challenge ☐ Climbing Wall ☐ Fitness & Instruction ☐ Intramural Sports ☐ Open Rec ☐ ORC Trip ☐ Personal Training ☐ Sport Club ☐ Youth Programs ☐ Other

Type of Activity that Caused Injury:

_____

_____

_____

Description of Injured Body Part(s) *(ex; Left Ankle or Right Thumb)*

_____

_____

_____

Description of Treatment Given

_____

_____

_____

SAMPLE (For Suspected Physical Injuries)

Signs and Symptoms:

Allergies:

Medications:

Pertinent Medical History:

Last oral intake:

Events Leading Up to the Incident:

Was Your Supervisor Alerted?: ☐ Yes ☐ No

Emergency Services Called: ☐ Yes ☐ No

If so, who?: ☐ Fire ☐ Police ☐ Other

Ambulance Called: ☐ Yes ☐ No

Did patient Request Ambulance?: ☐ Yes ☐ No

If ambulance was called:
☐ Patient was only assessed by EMT (no transport)
☐ Patient was treated and transported
☐ Patient declined treatment

Did person continue to participate:
☐ Yes ☐ No

Was disposal of biohazard required?
☐ Yes ☐ No

Is a follow up recommended?
☐ Yes ☐ No

Item(s) Used from Med Kit (Band Aid, Gauze, etc.):

Suspected Head Injury – did participant exhibit any of the following signs?:

	Headache or "pressure" in head		Double or blurry vision
	Sensitivity to light or noise		Feeling sluggish, hazy, foggy, or groggy
	Nausea or vomiting		Concentration or memory problems
	Balance problems or dizziness		Just not "feeling right" or is "feeling down"
	Confusion		Can't recall events prior to hit or fall
	Moves clumsily		Loses consciousness (even briefly)

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Witness Information

Name:	Phone Number:
Name:	Phone Number:
Name:	Phone Number:

Primary Responding Staff Information

Last Name:	First Name:	Staff WSU ID Number:
PHONE NUMBER:	EMAIL ADDRESS:	
STAFF SIGNATURE:		

Additional Information

Please write a detailed description of the incident - **If extra space is needed, please attach another sheet of paper**

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Follow up/Action Taken by Department Manager

☐ Near Miss *(an unplanned event that did not result in injury, illness, or damage but had the potential to do so)*

Form reviewed by:
Manager: _____ Date: ____/____/_____
Assistant Director: _____ Date: ____/____/_____
Risk Management Committee: _____ Date: ____/____/_____