



|  |  |
|--|--|
| DATE OF INCIDENT _____ TIME OF INCIDENT _____ AM / PM<br><b>Name of League:</b><br><br><b>Name of Association:</b><br><input type="checkbox"/> Mitey Mites <input type="checkbox"/> Jr. PeeWee <input type="checkbox"/> PeeWee <input type="checkbox"/> Jr. Midget<br><input type="checkbox"/> Midget <input type="checkbox"/> Jr. Bantam <input type="checkbox"/> Bantam <input type="checkbox"/> Flag Football | <b>DOES INJURED PERSON HAVE OTHER MEDICAL INSURANCE?</b><br><input type="checkbox"/> YES <input type="checkbox"/> NO<br>If yes, please provide the following information:<br><br>Company Name: _____<br><br>Policy #: _____  |
| <b>INJURED PERSON:</b> <input type="checkbox"/> Athlete <input type="checkbox"/> Official <input type="checkbox"/> Coach<br><input type="checkbox"/> Spectator <input type="checkbox"/> Volunteer <input type="checkbox"/> Other<br><br>Was injured person a member of Pop Warner? <input type="checkbox"/> Yes <input type="checkbox"/> No  | <b>DID THIS TAKE PLACE DURING (check all that apply):</b><br><br><input type="checkbox"/> Practice <input type="checkbox"/> Competition <input type="checkbox"/> While traveling<br><input type="checkbox"/> Fundraiser <input type="checkbox"/> Football <input type="checkbox"/> Flag Football <input type="checkbox"/> Spirit |

**INJURED PERSON INFORMATION (PLEASE PRINT)**

|           |        |   |                         |                                 |                                  |
|-----------|--------|---|-------------------------|---------------------------------|----------------------------------|
| Last Name | First  | Middle  | Telephone Number (   )  | <input type="checkbox"/> Single | <input type="checkbox"/> Married |
| Address   |        |   | Social Security Number: |                                 |                                  |
| City      |        | State   | Zip                     | Employer Name:                  |                                  |
| Age       | D.O.B. | <input type="checkbox"/> Male <input type="checkbox"/> Female |                         | Employer Address:               |                                  |

**GUARDIAN/PARENT (IF INJURED PERSON IS A MINOR)**

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

**SUSPECTED PRE-EXISTING CONDITION:**    Yes    No

|  |   |   |
|--|---|---|
| <b>INCIDENT LOCATION</b><br><input type="checkbox"/> Competition area <input type="checkbox"/> Concession area<br><input type="checkbox"/> Parking lot <input type="checkbox"/> Admission area<br><input type="checkbox"/> Restrooms/locker rooms <input type="checkbox"/> Off property<br><input type="checkbox"/> Premises/grounds <input type="checkbox"/> Store area<br><input type="checkbox"/> Bleachers/stands<br><br><b>CLASSIFICATION</b><br><input type="checkbox"/> Facility or event related <input type="checkbox"/> Non-injury<br><input type="checkbox"/> Not facility or event related<br><input type="checkbox"/> Minor injury or illness<br><input type="checkbox"/> Serious injury or illness   | <b>INCIDENT</b><br><input type="checkbox"/> Assault/Sexual <input type="checkbox"/> Slip, bodily reaction<br><input type="checkbox"/> Assault/Non-Sexual <input type="checkbox"/> Slip/Fall<br><input type="checkbox"/> Fall (different level) <input type="checkbox"/> Trip/Fall<br><input type="checkbox"/> Fall (same level) <input type="checkbox"/> Overexertion<br><input type="checkbox"/> Caught in, on, between<br><input type="checkbox"/> Animal/insect bite/sting<br><input type="checkbox"/> Collision (with object)<br><input type="checkbox"/> Collision (participant/participant)<br><input type="checkbox"/> Collision (participant/spectator)<br><input type="checkbox"/> Collision (spectator/spectator)<br><input type="checkbox"/> Struck by falling/flying object           | <b>MEDICAL SERVICES</b><br><input type="checkbox"/> Antacid <input type="checkbox"/> Eye rinse<br><input type="checkbox"/> Aspirin <input type="checkbox"/> Glucose<br><input type="checkbox"/> Aspirin substitute <input type="checkbox"/> Ice Pack<br><input type="checkbox"/> Bandaged <input type="checkbox"/> Oxygen<br><input type="checkbox"/> Ointment/antiseptic <input type="checkbox"/> Rest<br><input type="checkbox"/> Removal <input type="checkbox"/> Splinted<br><input type="checkbox"/> CPR <input type="checkbox"/> Wrapped<br><input type="checkbox"/> Cleansed <input type="checkbox"/> Exam<br><input type="checkbox"/> Cold Pack<br><input type="checkbox"/> None<br><b>Treated by</b> _____ |
| <b>PRIMARY INJURY</b><br><input type="checkbox"/> Allergy <input type="checkbox"/> Dislocation <input type="checkbox"/> Nausea<br><input type="checkbox"/> Amputation <input type="checkbox"/> Electrical Shock <input type="checkbox"/> Stroke<br><input type="checkbox"/> Abrasion <input type="checkbox"/> Foreign Body <input type="checkbox"/> Burn<br><input type="checkbox"/> Laceration <input type="checkbox"/> Fracture <input type="checkbox"/> Death<br><input type="checkbox"/> Drowning <input type="checkbox"/> Heat Exhaustion <input type="checkbox"/> Pain<br><input type="checkbox"/> Hypertension <input type="checkbox"/> Cardiac <input type="checkbox"/> Illness<br><input type="checkbox"/> Cold Injury <input type="checkbox"/> Contusion <input type="checkbox"/> Sting/bite<br><input type="checkbox"/> Seizures <input type="checkbox"/> Concussion<br><input type="checkbox"/> Strain/Sprain <input type="checkbox"/> Tooth/Mouth | <b>BODY PART INJURED</b><br><input type="checkbox"/> Eye(L/R) <input type="checkbox"/> Torso <input type="checkbox"/> Arm (L/R)<br><input type="checkbox"/> Nose <input type="checkbox"/> Back <input type="checkbox"/> Tooth<br><input type="checkbox"/> Neck <input type="checkbox"/> Face <input type="checkbox"/> Head<br><input type="checkbox"/> Ear (L/R) <input type="checkbox"/> Leg (L/R)<br><input type="checkbox"/> Knee (L/R) <input type="checkbox"/> Ankle (L/R)<br><input type="checkbox"/> Internal <input type="checkbox"/> Hip (L/R)<br><input type="checkbox"/> Shoulder (L/R) <input type="checkbox"/> Foot (L/R)<br><input type="checkbox"/> Elbow (L/R) <input type="checkbox"/> Hand (L/R)<br><input type="checkbox"/> Wrist (L/R) <input type="checkbox"/> Finger or Toe | <b>DISPOSITION</b><br><input type="checkbox"/> Released to parent <input type="checkbox"/> Police<br><input type="checkbox"/> Refusal of care <input type="checkbox"/> Ambulance<br><input type="checkbox"/> Refer to doctor <input type="checkbox"/> Report only<br><input type="checkbox"/> Refer to hospital or clinic<br><input type="checkbox"/> Medical attention<br><input type="checkbox"/> EMS transport<br><input type="checkbox"/> Patient requested EMS transport<br><input type="checkbox"/> Released to personal vehicle  |
| <b>Describe how the incident occurred:</b><br><br>_____  |   |   |

**WITNESS INFORMATION**

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

Any person who knowingly, and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony. This notice does not apply in Virginia.

**Signature of Coach or Official** \_\_\_\_\_ **DATE** \_\_\_\_\_ **Phone #** \_\_\_\_\_  
 (with no relationship to claimant)

**ATTACH ANY RELEVANT REPORTS**



## INCIDENT REPORT INSTRUCTIONS



### ***When an Accident Occurs:***

An incident report must be completed immediately and mailed to the address shown below. This holds true whether the person involved is a participant or a spectator, or whether or not you feel the incident will result in a claim.

Although you may not have sufficient information to answer all the questions, it is important that the form be completed as fully as possible. Do not delay sending in the report form; an incomplete form is better than none at all. Always include your name and daytime telephone number where indicated on the form.

The form contains sections to capture information regarding injury to persons, and damage to property.

If you have any questions regarding completion of the form, please call American Specialty Insurance Services at 1-800-245-2744.

### ***Mail the completed report to:***

American Specialty Insurance Services, Inc.  
ATTN: Claims Department  
142 N. Main Street, P.O. Box 309  
Roanoke, IN 46783-0309  
Phone (800) 566-7941 Fax (260) 673-1189

### ***In case of serious injury:***

Immediately notify American Specialty by calling 1-800-566-7941 (if after hours, follow the instructions for emergency claims reporting). This number is answered 24 hours a day, 365 days a year. It is important that you contact this claim line as soon as possible after a serious injury involving a participant or spectator.