

CARROLL COUNTY DEPARTMENT OF RECREATION AND PARKS

Participant Accident ~ Injury Form

Page 1 of ____ pages

Site/Location: Time Occurred: Time Reported:	PLEASE PRINT				and the second s	
Program Name/Recreation Council/Organization: Name of Person Injured: Address: Email: Body Part Injured (indicate left, right, back, front, etc.) Head	Reported By:	Date Occurred:		Date Reported:		
Name of Person Injured: Address: Email: Body Part Injured (indicate left, right, back, front, etc.) Head in person by phone email Date/Time:	Site/Location:	Time Occurred:		Time Report	red:	
Email: Body Part Injured (indicate left, right, back, front, etc.) Parent/Guardian Notified (required if under 18) Head in person by phone email Date/Time: Back Chest/Ribs Face Face Providing Care: Ear Nose Mouth Mouth Phone:	The same of the sa	cil/Organization:				
Body Part Injured (indicate left, right, back, front, etc.) Head in person by phone email Date/Time:	Address:		DOB:			
Body Part Injured (indicate left, right, back, front, etc.) Head				Telephone:		
(indicate left, right, back, front, etc.) Parent/Guardian Notified (required if under 18) □ Head □ in person □ by phone □ email □ Date/Time: □ Back □ Chest/Ribs □ Face □ Eye □ Ear □ Nose □ Mouth □ Mouth □ Phone:				Total state of the		
□ Back □ Chest/Ribs □	- 1/0 I' NI I'' I (
□ Chest/Ribs Name of Staff/Volunteer □ Face Providing Care: □ Eye Email: □ Nose Phone:	☐ Head	☐ in person ☐ by phone	e 🚨 email	Date/Tim	ne:	
	☐ Chest/Ribs ☐ Face ☐ Eye ☐ Ear ☐ Nose	BENEFIT STATE OF THE STATE OF	Name:			
- I Ambulance Collect	☐ Teeth	☐ Ambulance Called				
□ Neck/Throat (Notify Supervisor Immediately)				2.00		
□ Abdomen Care Given: □ Back □ Chest/Ribs □ Arm □ Elbow	☐ Back ☐ Chest/Ribs ☐ Arm	Care Given:			₩ A	
☐ Wrist Telephone:	☐ Wrist	Witness 1 Name:		Telephone	:	
☐ Hand	☐ Finger/Thumb	Address:	Email: Telephone:			
☐ Knee Witness 2 Name: Telephone:	☐ Knee	Witness 2 Name:				
□ Ankle Address: Email:	☐ Foot	Address:	Email:			
□ Toes □ Other:						
Description of Accident/Injury (in detail, facts only): Use back or attach additional sheets if necessary.	Description of Accident/Injury	(in detail, facts only): Use back	or attach ac	dditional shee	ets if necessary.	
Parent/Guardian Signature (if available) Date Date Phone:	Parent/Guardian Signature (if available)			ate	Phone:	
Staff/Volunteer Completing form (Print) : email:	Staff/Volunteer Completing form (Print) :			email:		
Staff/Volunteer Signature: Date Phone:	Staff/Volunteer Signature:			Date	Phone:	
Reports are due within 24 hours. Serious Accidents: email report immediately to Lisa Carroll at learroll@ccg.carr.org / or designated supervisor OR Fax to CCRP at 410-876-8284 Department Use Only: Copy to Risk Management? The Department Use Only: Copy to Risk Management? Yes No By Whom? Bureau Chief Initials						