



CARROLL COUNTY DEPARTMENT OF RECREATION AND PARKS

Participant Accident ~ Injury Form

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PLEASE PRINT

Reported By:	Date Occurred:	Date Reported:
Site/Location:	Time Occurred:	Time Reported:

Program Name/Recreation Council/Organization: \_\_\_\_\_

Name of Person Injured:	
Address:	DOB:
Email:	Telephone:

Body Part Injured (indicate left, right, back, front, etc.) Parent/Guardian Notified (required if under 18)

in person   
 by phone   
 email   
Date/Time: \_\_\_\_\_

- Head \_\_\_\_\_
- Back \_\_\_\_\_
- Chest/Ribs \_\_\_\_\_
- Face \_\_\_\_\_
- Eye \_\_\_\_\_
- Ear \_\_\_\_\_
- Nose \_\_\_\_\_
- Mouth \_\_\_\_\_
- Teeth \_\_\_\_\_
- Neck/Throat \_\_\_\_\_
- Shoulder/Collar Bone \_\_\_\_\_
- Abdomen \_\_\_\_\_
- Back \_\_\_\_\_
- Chest/Ribs \_\_\_\_\_
- Arm \_\_\_\_\_
- Elbow \_\_\_\_\_
- Wrist \_\_\_\_\_
- Hand \_\_\_\_\_
- Finger/Thumb \_\_\_\_\_
- Leg \_\_\_\_\_
- Knee \_\_\_\_\_
- Ankle \_\_\_\_\_
- Foot \_\_\_\_\_
- Toes \_\_\_\_\_
- Other: \_\_\_\_\_

<b>Name of Staff/Volunteer Providing Care:</b>  <input type="checkbox"/> Ambulance Called (Notify Supervisor Immediately)	<b>Contact Info of Staff/Volunteer Providing Care:</b> Name: _____ Email: _____ Phone: _____ Hospital/Medical Contact: _____
<b>Care Given:</b>	
Witness 1 Name: _____	Telephone: _____
Address: _____	Email: _____
Witness 2 Name: _____	Telephone: _____
Address: _____	Email: _____

Description of Accident/Injury (in detail, facts only): Use back or attach additional sheets if necessary.

Parent/Guardian Signature (if available) \_\_\_\_\_ Date \_\_\_\_\_ Phone: \_\_\_\_\_

Staff/Volunteer Completing form (Print) : \_\_\_\_\_ email: \_\_\_\_\_

Staff/Volunteer Signature: \_\_\_\_\_ Date \_\_\_\_\_ Phone: \_\_\_\_\_

Reports are due within 24 hours. Serious Accidents: email report immediately to Lisa Carroll at [lcarroll@ccg.carr.org](mailto:lcarroll@ccg.carr.org) / or designated supervisor OR Fax to CCRP at 410-876-8284

Department Use Only: Copy to Risk Management? Yes No By Whom? \_\_\_\_\_ Bureau Chief Initials \_\_\_\_\_