



Personal Injury Report Form

Date: _____	Time: _____
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Name of Injured Person _____ DOB: _____

Address _____

Name of Parent (If injured person is a junior/Student) _____

Phone _____ Email _____

Name of Venue/ Lake/ River _____	
Type of Rowing at time of injury <input type="checkbox"/> Training <input type="checkbox"/> Social Rowing <input type="checkbox"/> Competition Other _____	Where did the injury occur <input type="checkbox"/> On the water <input type="checkbox"/> In the boat <input type="checkbox"/> On land <input type="checkbox"/> On the pontoon Other _____
Body Part Injured <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> NA <input type="checkbox"/> Head <input type="checkbox"/> Chest <input type="checkbox"/> Hip <input type="checkbox"/> Neck <input type="checkbox"/> Shoulder <input type="checkbox"/> Knee <input type="checkbox"/> Face <input type="checkbox"/> Arm <input type="checkbox"/> Leg <input type="checkbox"/> Eye <input type="checkbox"/> Elbow <input type="checkbox"/> Ankle <input type="checkbox"/> Nose <input type="checkbox"/> Wrist <input type="checkbox"/> Feet <input type="checkbox"/> Mouth <input type="checkbox"/> Hand <input type="checkbox"/> Other _____ <input type="checkbox"/> Back	Nature of Injury <input type="checkbox"/> Concussion <input type="checkbox"/> Respiratory <input type="checkbox"/> Laceration <input type="checkbox"/> Cardiac <input type="checkbox"/> Fracture <input type="checkbox"/> Stroke <input type="checkbox"/> Dislocation <input type="checkbox"/> Cold Related <input type="checkbox"/> Sprain <input type="checkbox"/> Heat Related Other _____ Other _____

Description of Injury and any first Aid required:

Details of Hospitals, doctors or any other agency, involved.

Name and Signature of person reporting incident _____

Signature of Safety Officer _____