|  |  |  |  |
| --- | --- | --- | --- |
| Name of injured: |  | Date: |  |
| Location: |  | Time: |  |
| Parent/Guardian: |  | Phone: |  |
| Witnesses: |  |  |  |
| Describe injury: |  |  |  |
|  |  |  |  |
|  |  |  |  |
| How did it happen? |  |  |  |
|  |  |  |  |
| Signs/Symptoms: |  |  |  |
| **Concussion symptoms: If present or uncertain, follow District concussion protocol** |  |
| Care provided: |  |  |  |
|  |  |  |  |



|  |  |
| --- | --- |
| Signature: |  |
|  |  |
| Position/Title: |  |

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**Doctor/Provider’s release needed? Yes No**

|  |  |
| --- | --- |
| Doctor’s Notes: |  |
|  |  |
|  |  |
|  |  |
|  |  |
| Signature: |  |
| Date: |  |