



# FHF, Inc. INCIDENT REPORT FORM

Complete this form for any of the following: (check type)

Injury/Illness  Threats  Fights  Property Damage  Calls to Police  Other

Return **completed** form to the FHF Director of Competitions, Secretary and/or Tournament Director.

AFFECTED PARTY:  Player  Official  Coach  Spectator  Volunteer  Other

Last Name		First Name		MI	Birth date:	
Address:					Phone:	
City:			State:	Zip:		

Does the injured person have medical insurance?  
 YES  NO  *If yes, please provide name of company and policy #:*

**GUARDIAN/PARENT (if affected party is a minor):**

Last Name	First Name	Address (if different than above):	
Email 1:		Cell Ph:	
Email 2:		Cell Ph:	
Email 3:		Cell Ph:	

<b>INCIDENT INFO:</b>	Date of Incident:	Age Division:	<input type="checkbox"/> Boys <input type="checkbox"/> Girls <input type="checkbox"/> Co-ed	Time of Incident:
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Location (if applicable-Tournament name):

Team Involved #1:	Coach Name:	Division:
Team Involved #2:	Coach Name:	Division:

FOR INJURIES: BODY PART INJURED			TYPE OF INJURY/ILLNESS			FIELD SURFACE	LOCATION
<input type="checkbox"/> Ankle (L/R)	<input type="checkbox"/> Shoulder(L/R)	<input type="checkbox"/> Tooth	<input type="checkbox"/> Abrasion	<input type="checkbox"/> Dislocation	<input type="checkbox"/> Pain	<input type="checkbox"/> Dirt	<input type="checkbox"/> Before Competition/Event
<input type="checkbox"/> Knee (L/R)	<input type="checkbox"/> Wrist (L/R)	<input type="checkbox"/> Back	<input type="checkbox"/> Burn	<input type="checkbox"/> Foreign Body	<input type="checkbox"/> Seizures	<input type="checkbox"/> Grass	<input type="checkbox"/> During Competition/Event
<input type="checkbox"/> Leg	<input type="checkbox"/> Finger	<input type="checkbox"/> Neck	<input type="checkbox"/> Cardiac	<input type="checkbox"/> Fracture	<input type="checkbox"/> Sting/Bite	<input type="checkbox"/> Turf	<input type="checkbox"/> After Competition/Event
<input type="checkbox"/> Foot	<input type="checkbox"/> Eye (L/R)	<input type="checkbox"/> Internal	<input type="checkbox"/> Cold Injury	<input type="checkbox"/> Heat Exhaustion	<input type="checkbox"/> Strain	<input type="checkbox"/> Indoor	<input type="checkbox"/> Concession Area
<input type="checkbox"/> Toe	<input type="checkbox"/> Ear (L/R)	<input type="checkbox"/> No injury	<input type="checkbox"/> Concussion	<input type="checkbox"/> Laceration	<input type="checkbox"/> Sprain		<input type="checkbox"/> Parking Lot
<input type="checkbox"/> Arm	<input type="checkbox"/> Nose	<input type="checkbox"/> Other	<input type="checkbox"/> Contusion	<input type="checkbox"/> Nausea	<input type="checkbox"/> COVID-19		<input type="checkbox"/> Restrooms
<input type="checkbox"/> Hand	<input type="checkbox"/> Head						

CAUSE	OUTCOME		POLICE REPORT FILED:	
<input type="checkbox"/> Collision (participant/spectator) <input type="checkbox"/> Struck by falling/flying object <input type="checkbox"/> Struck by or fell into goal <input type="checkbox"/> Animal/insect bite/sting <input type="checkbox"/> Slip/Fall <input type="checkbox"/> Assault/Sexual <input type="checkbox"/> Assault/Non-Sexual <input type="checkbox"/> Property Damage	<i>No care given:</i> <input type="checkbox"/> Not Needed <input type="checkbox"/> Patient Refused  <i>Released:</i> <input type="checkbox"/> To Parent <input type="checkbox"/> To Personal Vehicle	<i>Referral:</i> <input type="checkbox"/> To Doctor <input type="checkbox"/> To Hospital/Clinic  <i>EMS transport:</i> <input type="checkbox"/> Region Recommended <input type="checkbox"/> Patient/Parent Requested	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Report No:</i>  <i>Officer's Name &amp; Contact No:</i>

Describe how the incident, injury or property damage occurred:  
*(use the backside or attach a separate sheet if necessary – may attach a copy of the Referee Game Misconduct Report)*

WITNESS INFORMATION – Confidential		
Name	Address	Phone Number

Person/volunteer completing/submitting this form:		
Name:	Signature:	Cell:
Position Title:	E-mail address:	Date:
RC or Safety Director (print name):	Signature:	Date:

**FHF, Inc. ONLY: Email completed form to: [fhf.socal.secretary@gmail.com](mailto:fhf.socal.secretary@gmail.com)**