



SPECIAL OLYMPICS

FIRST REPORT OF ACCIDENT / INCIDENT



U.S. Program/Area: Date of Incident: _____

Injured Person/Party Information Date of Birth: ____/____/____ Age: _____
Name: _____
(Last) (First) (MI)
Address: _____
(Street) (City) (State) (Zip)
Home Phone: (____)____-____ Work Phone: (____)____-____
Gender: Male Female Social Security Number: ____-____-____

Type of Injury/ Accident:
 Bodily Injury
 Property Damage
 Automobile
 Other: _____

Injured Party:
 Athlete
 Volunteer
 Coach
 Employee
 Spectator
 Unified Partner
 Property Owner
 Other: _____

Description of Accident (If automobile accident occurred, please attach a copy of the police report).

Describe how the accident occurred (Attach a separate sheet if necessary): _____

Site / event where accident occurred: _____

Accident Occurred During:
 Training/Practice
 Competition
 Traveling to or from SO event
 Other: _____

Type of Injury:
 Severe cut w/ bleeding
 Less serious bruise or cut
 Break/fracture
 Concussion
 Paralysis
 Fatality
 Other: _____

Disposition:
 Released to parent
 Refusal of care
 Refer to doctor
 Refer to hospital or clinic
 Medical attention
 EMS transport
 Patient requested EMS transport
 Released to personal vehicle
 Police
 Ambulance
 Report only
 Other: _____

Sport
 Alpine Skiing
 Aquatics
 Athletics
 Badminton
 Baseball
 Basketball
 Bocce
 Bowling
 Cheerleading
 Cross Country Ski
 Cycling
 Equestrian
 Figure Skating
 Floor Hockey
 Golf
 Gymnastics
 Kickball
 Power Lifting
 Relay Game
 Roller Skating
 Sailing
 Snowboarding
 Snowshoe
 Soccer
 Softball
 Speed Skating
 Swimming
 Table Tennis
 Team Handball
 Tennis
 Track & Field
 Volleyball
 Other: _____

Body Part Injured:
 Head
 Neck
 Torso
 Back
 Hand (L / R)
 Finger (L / R)
 Elbow (L / R)
 Shoulder (L / R)
 Leg (L / R)
 Knee (L / R)
 Thigh (L / R)
 Shin (L / R)
 Toe (L / R)
 Other: _____

Contact / Care Provider Information (If an athlete or underage volunteer was injured, please identify the care provider and/or responsible party (e.g. parent, legal guardian).

Relationship to the injured person: _____
Name: _____
Address: _____
Home Phone: (____)____-____

Employer Name: _____
Employer Address: _____
Work Phone: (____)____-____

Does the injured person have medical insurance?
If yes, insurance is provided by:
Please provide name of Company and Policy Number: _____

Yes No
 Injured Person Care Provider/Responsible Party

Witness Information (Please provide names and phone numbers of any witnesses to the incident)

Witness #1 Name: _____
Witness #2 Name: _____

Daytime Phone: (____)____-____
Daytime Phone: (____)____-____

Special Olympics Official / Representative (other than claimant)

Name: Eamonn Garvey
Signature: _____

Daytime Phone: (703) 359-4301

Send completed form to:
If injury was serious or a fatality:

American Specialty Insurance Services, Inc., P.O. Box 459, Roanoke, IN 46783-0309; Fax: (260) 673-1291
IMMEDIATELY notify American Specialty Insurance Services, Inc.
Telephone: (800) 566-7941 (24 hours a day / 7 days a week)