



CARROLL COUNTY DEPARTMENT OF RECREATION AND PARKS

Participant Accident - Injury Form

Reported By:	Date Occurred:	Date Reported:								
Site/Location:	Time Occurred:	Time Reported:								
Program Name/Recreation Council/Organizaition: _____										
Name of Person Injured:										
Address:		DOB:								
Email:		Telephone:								
<table style="width: 100%; border: none;"> <tr> <td style="width: 30%; border: none;">Body Part Injured (indicate left, right, back, front, etc.)</td> <td style="width: 40%; border: none; text-align: center;">Parent/Guardian Notified (required if under 18)</td> <td style="width: 30%; border: none;"></td> </tr> <tr> <td style="border: none;"> 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: _____ </td> <td style="border: none; text-align: center;"> in person by phone email Date/Time: _____ </td> <td style="border: none;"></td> </tr> </table>			Body Part Injured (indicate left, right, back, front, etc.)	Parent/Guardian Notified (required if under 18)		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: _____	in person by phone email Date/Time: _____			
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<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%; padding: 5px;">Name of Staff/Volunteer Providing Care:</td> <td style="width: 40%; padding: 5px;">Contact info of Staff/Volunteer Providing Care:</td> </tr> <tr> <td style="height: 40px;"></td> <td style="padding: 5px;">Name: _____</td> </tr> <tr> <td></td> <td style="padding: 5px;">Email: _____</td> </tr> <tr> <td></td> <td style="padding: 5px;">Phone: _____</td> </tr> </table>		Name of Staff/Volunteer Providing Care:	Contact info of Staff/Volunteer Providing Care:		Name: _____		Email: _____		Phone: _____	Hospital/Medical Contact:
Name of Staff/Volunteer Providing Care:	Contact info of Staff/Volunteer Providing Care:									
	Name: _____									
	Email: _____									
	Phone: _____									
Ambulance Called (Notify Supervisor Immediately)										
Care Given:										
Witness 1 Name:		Telephone:								
Address:		Email:								
Witness 1 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@carrollcountymd.gov / 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 _____