



KPPW POP WARNER INJURY REPORT

SECTION I.

Name: _____ **Date/Time of Injury:** _____

Location: _____

Injured Person is: _____ **Player** _____ **Cheerleader** _____ **Coach** _____ **Spectator** _____ **Other** _____

Association: _____ **Division:** _____ **TM** _____ **MM** _____ **JPW** _____ **PW** _____ **CDT** _____ **Other** _____

Involved Person: _____ **Type:** **Player** _____ **Cheer** _____ **Coach** _____ **Spectator** _____ **Other** _____

Involved Person: _____ **Type:** **Player** _____ **Cheer** _____ **Coach** _____ **Spectator** _____ **Other** _____

Witnesses to Injury:

Name: _____ **Title:** _____ **Phone #** _____

Name: _____ **Title:** _____ **Phone #** _____

Name: _____ **Title:** _____ **Phone #** _____

SECTION II. INJURY DETAILS

Significance of Injury: _____ **Insignificant** _____ ***Serious** _____ ***Critical** _____ ***Life** _____

Threatening *If serious, critical or life threatening, please complete section IV.

Injury Occurred During: _____ **Practice** _____ **Scrimmage** _____ **Game** _____ **Other** _____

Type of Injury: _____ **Neurological** _____ **Skin** _____ **Bone** _____ **Muscle** _____ **Soft Tissue** _____ **Other** _____

Check all that apply

Describe Injury(s):

Describe exact circumstances which led to injury:

Describe how injury was dealt with:

Describe any medical treatment/first aid provided:

Who provided medical treatment:

Name: _____ **Title** _____ **Phone number** _____

Name: _____ **Title** _____ **Phone number** _____

KPPW POP WARNER INJURY REPORT

Section III. For Minor Injuries Fill Out This Section:		
Did participant return to activity? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how long was out of activity? _____Min		
If no was child released to parent/guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If no, was parent/guardian contacted: <input type="checkbox"/> Yes <input type="checkbox"/> No _____		
Describe (who called, etc): _____		
Who picked up participant? _____ Relationship to participant? _____		
Section IV. For Serious Injuries Fill Out This Section:		
Was there Loss of Consciousness? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, how long? _____min _____		
Was the participant dazed or did he become disoriented? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how long? _____Min		
Did participant vomit or behave unusually? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe: _____		
Was EMS called? <input type="checkbox"/> Yes <input type="checkbox"/> No, if yes, how long before they arrived? _____Min		
Was EMS recommendation to take participant to the hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes describe details: _____		
If No, was parent/guardian contacted about the injury <input type="checkbox"/> Yes <input type="checkbox"/> No		
If potential concussion, was parent given concussion info packet & Return to Play Form? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Describe (who called, etc.): _____		
If no, who picked up participant? _____ Relationship to participant? _____		
SECTION V. MANAGEMENT TO COMPLETE THIS SECTION		
If Section III Completed: Did Participant seek alternate medical treatment?: <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Section IV Completed: Did Participant return with note from Doctor to return to activity? <input type="checkbox"/> Y <input type="checkbox"/> N _____		
In your opinion, was this injury preventable? <input type="checkbox"/> Yes <input type="checkbox"/> No How? _____		
What other recommendations would you make? _____		
Signature:	Date:	Title:
Signature:	Date:	Title:
Signature:	Date:	Title:
Signature:	Date:	Title:

THIS FORM MUST BE COMPLETED AND TURNED IN WITHIN 72 HOURS OF INCIDENT.

PLEASE EMAIL TO INFO@KPPWSAINTS.COM