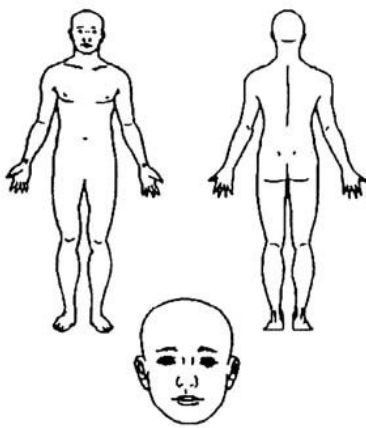


**Injury details: This report reflects an accurate record of the injured person's reported symptoms of injury**  
**COACH/MANAGER – Please retain a copy of this form. The original should be forwarded to the MABA**

Name of injured person:		Date of birth / / Day month year																						
Date when the injury occurred		Date when injury is evident																						
Person injured: Athlete Coach Other		Gender: M F																						
Supervising coach: _____ (Signature)		Witness: _____ (Signature)																						
First aid provided _____ (Signature)	Time of first aid	Initial treatment:  No treatment required CPR RICER Crutches Sling/splint Dressing Strapping Massage Stretching																						
Nature of injury: New injury Aggravated injury Recurrent injury Other																								
Did the injury occur during: Training Event Other:																								
Symptoms of injury:																								
<table border="0"> <tr> <td>Blisters</td> <td>Cramp</td> <td>Sprain</td> </tr> <tr> <td>Inflammation/swelling</td> <td>Cardiac problem</td> <td>Loss of consciousness</td> </tr> <tr> <td>Spinal injury Burn</td> <td>Bruising/contusion</td> <td>Poisoning</td> </tr> <tr> <td>Graze/abrasion</td> <td>Suspected bone fracture/break</td> <td>Strain</td> </tr> <tr> <td>Concussion/head injury</td> <td>Electrical shock</td> <td>Respiratory problem</td> </tr> <tr> <td>Insect bite/sting</td> <td>Cut</td> <td>Bleeding nose</td> </tr> <tr> <td></td> <td>Dislocation</td> <td>Other:</td> </tr> </table>				Blisters	Cramp	Sprain	Inflammation/swelling	Cardiac problem	Loss of consciousness	Spinal injury Burn	Bruising/contusion	Poisoning	Graze/abrasion	Suspected bone fracture/break	Strain	Concussion/head injury	Electrical shock	Respiratory problem	Insect bite/sting	Cut	Bleeding nose		Dislocation	Other:
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Insect bite/sting	Cut	Bleeding nose																						
	Dislocation	Other:																						
Body part injured:		How did the injury occur?																						
<p>right left left right</p> 		<ul style="list-style-type: none"> <li>Collision with a fixed object</li> <li>Overbalance</li> <li>Collision/contact with another person</li> <li>Overstretch</li> <li>Fall from height/awkward landing</li> <li>Slip/trip</li> <li>Fall/stumble on same level</li> <li>Other – please give details:</li> </ul>																						
		Was protective equipment worn on the injured body part?																						
		Yes No																						
Follow up action: None Medical practitioner/physiotherapist Hospital Ambulance Other:																								
Signature of person completing form: Date: / /20																								