



UNIVERSITY OF COLORADO – BOULDER

Student Recreation Center Injury Report

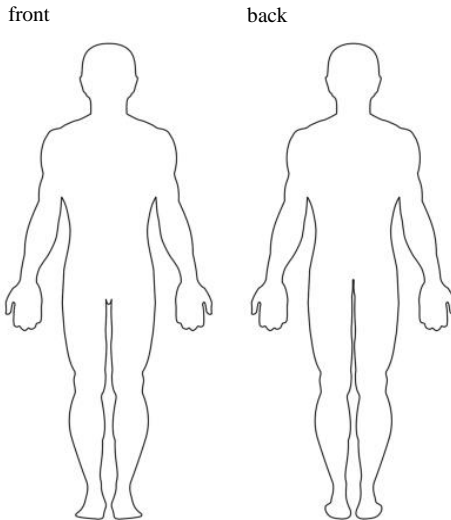
Athlete/Patron Information

Last name	_____	First name	_____
Classification	<input type="checkbox"/> Student <input type="checkbox"/> Faculty/Staff <input type="checkbox"/> Alumni <input type="checkbox"/> Guest/Other (explain) _____		
Student ID#	_____ - _____ - _____	Grad Year	_____
Birth Date	____/____/____	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Activity/Sport at time of Injury:	_____	Which gender best describes you?	_____
Program/Group:	<input type="checkbox"/> Club Sports <input type="checkbox"/> Outdoor Program	<input type="checkbox"/> Informal Rec <input type="checkbox"/> Intramurals <input type="checkbox"/> Fitness/Wellness <input type="checkbox"/> Other: _____	
Email	_____		
Contact Phone	_____ - _____ - _____		

Injury Information

Location:	_____		
Date	____/____/____	Time	_____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
Treated:	<input type="checkbox"/> Rec Staff <input type="checkbox"/> ATC/Other: _____		
Was injured party advised to seek further treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Was an ambulance recommended?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was injured party advised to discontinue further activity?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Was an ambulance called?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Did injured party discontinue further activity?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Did injured party refuse treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Did injured party sign a refusal form?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Injury location & type (mark and fill in)



Description: _____

Description of how the injury occurred:

What care was provided and what action was taken?

Participant left facility by:

Self
 With Friends
 Ambulance
 University Police
 Other _____

First Aid Rendered (if applicable):

Stopped Bleeding
 Washed Wound
 Bandage/Tape
 ICE
 Splint
 Kept Immobile
 Recovery Position
 CPR
 None
 Other _____

Employee name: _____	Witness name: _____
Department: _____	Witness phone: _____
Signature: _____	Signature of Injured Party: _____
	Date: _____

SportsWare entered by: _____ Date: _____ Follow-up by: _____ Date: _____ Status: _____

Refusal of Medical Treatment and Transport

Attendant Name: _____

Individual Name: _____

Address: _____

City/State/Zip _____ Phone: _____

Assessment of Individual

Is the individual over 18 years old?*Yes No*

Is the individual oriented to person, place, and time?*Yes No*

Does the individual have a decreased level or responsiveness?*Yes No*

Does the individual admit to loss of consciousness or hitting head?.....*Yes No*

Has the individual admitted to alcohol or drug use?*Yes No*

If the individual is over 18, oriented and does not have a decreased level of responsiveness, head injury, or drug/alcohol use then have them read and sign the bottom of refusal form. If the individual is under 18 or has any of the previously mentioned signs then call EMS and allow them to evaluate the individual.

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Individual Statement

I _____ understand that this form has been given to me because I have refused medical care or transport. I understand that University of Colorado Recreation Staff have recommended that I receive medical care, treatment and/or transportation to the hospital emergency department for further evaluation by a physician and that delaying this help may result in my condition worsening

I have made the decision to refuse medical treatment or transport being a competent adult, alert and oriented, and free of alcohol, drugs, or head injury which may impair my judgment. By making this decision to refuse medical treatment or transport I agree to assume all risk of personal injury, loss, or bodily injury (including death). I release, waive, hold harmless, and discharge the University of Colorado and its employees from all claims, damages, and injuries arising out of my refusal of medical treatment or transport.

Individual signature: _____ Date: _____

Witness Signature: _____ Date: _____