University of Colorado Colorado Springs  
Campus Recreation  
Injury/Accident Report

To be used for all injuries which occur within Campus Recreation Facilities or during a Campus Recreation Program. This report is required for all incidents involving bodily injury and is to be filled out by Campus Recreation staff. Please Print Clearly with Pen.

Date of Injury _____/_____/______  Time of Injury____:____ am / pm

□ Rec Employee Injured While Working

https://www.cu.edu/risk/forms/employees-injury-report-form (must be completed within 4 working days of the accident)

Name of Injured Person ___________________________  Team Name (if applicable) ________________
Gender: ________________ Age: _________ Name or Parent/Guardian if under 18 ________________
Address: __________________________ City, State Zip ________________

Campus or Home Phone Number__ (___)__________________________

ID Classification: □ Student □ Fac/Staff □ Affiliate/Associate □ Guest/Community □ Other __________

DETAILS OF INJURY

<table>
<thead>
<tr>
<th>TYPE</th>
<th>BODY PART AFFECTED</th>
<th>LOCATION</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Bleeding</td>
<td>□ Head</td>
<td>□ Back</td>
<td>□ Left</td>
</tr>
<tr>
<td>□ Bruise</td>
<td>□ Face</td>
<td>□ Ribs</td>
<td>□ Right</td>
</tr>
<tr>
<td>□ Cut or Abrasion</td>
<td>□ Neck</td>
<td>□ Chest</td>
<td>□ Front</td>
</tr>
<tr>
<td>□ Fainted (needs 911 call)</td>
<td>□ Arm</td>
<td>□ Leg</td>
<td>□ Back</td>
</tr>
<tr>
<td>□ Possible Fracture</td>
<td>□ Wrist</td>
<td>□ Knee</td>
<td>□ Upper</td>
</tr>
<tr>
<td>□ Possible Joint Injury</td>
<td>□ Hand</td>
<td>□ Ankle</td>
<td>□ Lower</td>
</tr>
<tr>
<td>□ Possible Muscle Injury</td>
<td>□ Finger</td>
<td>□ Foot</td>
<td>□ Other______</td>
</tr>
<tr>
<td>□ Possible Shock</td>
<td>□ Abdomen</td>
<td>□ Toe</td>
<td></td>
</tr>
<tr>
<td>□ Other________________</td>
<td>□ Shoulder</td>
<td>□ Other______</td>
<td></td>
</tr>
</tbody>
</table>

DETAILS OF ACCIDENT

ACCIDENT LOCATION: (Check facility and write specific name of area)
Facility: □ GRWC(Gallogly Recreation & Wellness Center) □ Alpine Field □ Mountain Lion Stadium
□ Other ___________________________________________________________________________

Exact Location of Accident: (Detailed location/room) ____________________________________________

PROGRAM & ACTIVITY DURING WHICH ACCIDENT OCCURRED:
(Choose appropriate program and write specific name of activity i.e. what was the victim doing?)

Program: □ Drop in Rec □ Rec Program/Class □ Sport Club □ Intramurals
□ Rental (Non-Rec Sponsored) □ Special Event (Rec Sponsored) □ Other ______________

Activity: (Write in- i.e. basketball/practice/Zumba class/swimming/treadmill/lacrosse/etc.) __________________

DESCRIPTION OF THE ACCIDENT: (Include only the facts. Describe events resulting in injury; what and how it happened; your observations. Use backside or second sheet of paper if necessary.): __________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

Rec Equipment Involved/Damaged? □ No □ Yes  Description/Name ___________________________ ID number __

ACTION TAKEN

Name of Responder(s): ____________________________

Was First Aid Rendered: □ Yes □ No  Victim Self Treated: □ Yes □ No

FIRST AID TREATMENT PROVIDED (check all that apply):
□ Adhesive Bandage □ Control Bleeding □ Ice □ Injury Immobilization □ Treated for Shock
□ Other ____________________________
EMERGENCY SERVICES ASSISTANCE

911 Called: □ Yes □ No  Public Safety Called: □ Yes □ No
911 Requested by Participant: □ Yes □ No  Public Safety Requested by Participant □ Yes □ No
If 911 was called include the following information:
TRANSPORTED (BY EMS or another person) □ Yes □ No
If No, then who:__________________ Relationship To Victim:__________________ Student ID#____________
METHOD of TRANSPORT: □ Ambulance □ Public Safety □ Personal Vehicle □ Other ____________
TRANSPORTED TO: □ Unknown □ Hospital □ Urgent Care □ Wellness Center
□ Home □ Other ____________

BASIC PRECAUTIONS REPORT

Was there blood or Other Potential Infectious Material (OPIM) present:
□ No Blood or (OPIM) was present
□ Blood or OPIM was present but victim self treated
□ Blood or OPIM was present and DRS employee provided direct assistance.
What was the volume of OPIM:
□ Minor to Moderate Volume (disinfect, place blood spill clean up materials (ie paper towels, gloves, etc.) in white/clear bag, and place in dumpster)
□ Large Volume (place saturated blood spill clean up materials in Red Biohazard bag and place in Red Biohazard Bin located in the laundry room, Wellness Center, Alpine or Lifeguard Office)
Note: Any Rec towels that are unsaturated, place in regular laundry to be washed

ADDITIONAL NOTES (as needed)

____________________________

PARTICIPANT SIGNATURE

Signature: __________________________ Print Name:______________________________

PARTICIPANT UNABLE TO SIGN: (Reason)______________________________

BM Signature: __________________________ Print Name:____________________________

WITNESSES

Note to Campus Recreation Employee: Needed for only serious or critical injuries. Witnesses who saw the injury occur should be included and written statements should be taken (separate sheet of paper).

Name of Witness_________________________Address_______________________Phone (      ) ____-_____
Name of Witness_________________________Address_______________________Phone (      ) ____-_____

REFUSAL OF ASSISTANCE

I have been advised by Recreational Sports Staff that I should be treated and/or evaluated. I am refusing this assistance.
Participant Signature: __________________________ Participant Printed Name:________________________

I (Rec Employee) advised the participant that he/she should be treated and/or evaluated. My signature indicates participant refused assistance and also would not sign above.
Rec Staff Signature: __________________________ Rec Staff Printed Name:________________________

EMPLOYEE SIGNATURES  Form must be completed and turned into Area Coordinator within 24 hours of injury.

Form Completed By (signature) __________________________ Print Name:________________________ Date __/__/____

Supervisor on Duty (if none leave blank)________________________ Print Name:________________________ Date __/__/____

Area Coordinator (reviewed)________________________ Print Name:________________________ Date __/__/____

RISK MANAGEMENT COMMITTEE MEMBER USE ONLY

Date Entered into Database: ______________ Initial: ______________

Updated 6/26/2018 BF