

# ACCIDENT INCIDENT REPORT FORM LACROSSE

**PLEASE COMPLETE THIS FORM WHENEVER A LACROSSE ACCIDENT OCCURS WHICH REQUIRES SOME FORM OF MEDICAL ATTENTION. INCLUDES ATHLETES, OFFICIALS, COACHES AND VOLUNTEERS, ETC. THIS FORM MUST ACCOMPANY ANY MEDICAL OR DENTAL CLAIM.**

**SEND IMMEDIATELY TO:**

ONTARIO LACROSSE ASSOCIATION  
1185 Eglinton Ave. E., Suite 607  
North York, ON M3C 3C6

Phone: (416) 426-7066 Fax: (416) 426-7382

The information which you provide on this form allows us to establish causes of and types of injuries related to lacrosse as part of a long term research effort to improve preventative measures.

Please indicate activity in which injured person was participating:

- Practice
- Game
- Sanctioned Tournament
- Non-Sanctioned Tournament

Please state whether the activity was:  Indoor  Outdoor

Name of Injured Person: \_\_\_\_\_  
Surname Given Name

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code \_\_\_\_\_

Phone # ( ) \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Male \_\_\_ Female \_\_\_

Date of Accident \_\_\_\_\_ Location of Accident \_\_\_\_\_

Club Name \_\_\_\_\_ Address \_\_\_\_\_

Team Name \_\_\_\_\_ League Name \_\_\_\_\_

Age Group: Under 18 \_\_\_\_\_ Over 18 \_\_\_\_\_

**PLEASE CHECK APPROPRIATE BOX TO DESCRIBE ACCIDENT:**

- |  |  |
|--|--|
| <input type="checkbox"/> Collision with another player | <input type="checkbox"/> Hit with stick      |
| <input type="checkbox"/> Collision with goalie         | <input type="checkbox"/> Hit with ball       |
| <input type="checkbox"/> Collision with net            | <input type="checkbox"/> Hit from behind     |
| <input type="checkbox"/> Collision with boards         | <input type="checkbox"/> Jumping over player |
| <input type="checkbox"/> Trip (no contact)             | <input type="checkbox"/> Surface problem     |

If hit with stick, what type of stick:    Plastic stick            Wood stick

Was a foul called:    YES            NO

Against you:        YES            NO

What Infraction:

- |   |                                   |                                      |
|---|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Fighting       | <input type="checkbox"/> Roughing | <input type="checkbox"/> Tripping    |
| <input type="checkbox"/> Dangerous play | <input type="checkbox"/> Tackling | <input type="checkbox"/> Other _____ |

**PLEASE CHECK EQUIPMENT INJURED PERSON WAS WEARING:**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Helmet no mask   | <input type="checkbox"/> Kidney pads   | <input type="checkbox"/> Shin pads       |
| <input type="checkbox"/> Helmet full mask | <input type="checkbox"/> Shoulder pads | <input type="checkbox"/> Knee pads       |
| <input type="checkbox"/> Full mouth guard | <input type="checkbox"/> Elbow pads    | <input type="checkbox"/> Lacrosse gloves |
| <input type="checkbox"/> Other gloves     |  |  |

**PLEASE INDICATE TYPE OF INJURY: (this accident)**

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Dental        | <input type="checkbox"/> Concussion      | <input type="checkbox"/> Fracture        | <input type="checkbox"/> Bruise                |
| <input type="checkbox"/> Muscle pull   | <input type="checkbox"/> Sprain (joints) | <input type="checkbox"/> Internal Injury | <input type="checkbox"/> Skin (wound/puncture) |
| <input type="checkbox"/> Torn ligament | <input type="checkbox"/> Dislocation     | <input type="checkbox"/> Laceration      | <input type="checkbox"/> Torn cartilage        |

**PLEASE INDICATE THE BODY PARTS INJURED: (this accident)**

- |                                      |                                    |                                |                                      |                                |  |
|--------------------------------------|------------------------------------|--------------------------------|--------------------------------------|--------------------------------|--|
| <input type="checkbox"/> Knee        | <input type="checkbox"/> Hip       | <input type="checkbox"/> Teeth | <input type="checkbox"/> Hand        | <input type="checkbox"/> Ankle | <input type="checkbox"/> Back            |
| <input type="checkbox"/> Face        | <input type="checkbox"/> Fingers   | <input type="checkbox"/> Foot  | <input type="checkbox"/> Spine       | <input type="checkbox"/> Neck  | <input type="checkbox"/> Upper arm       |
| <input type="checkbox"/> Chest       | <input type="checkbox"/> Chin      | <input type="checkbox"/> Wrist | <input type="checkbox"/> Thigh       | <input type="checkbox"/> Eye   | <input type="checkbox"/> Achilles Tendon |
| <input type="checkbox"/> Nose        | <input type="checkbox"/> Shoulder  | <input type="checkbox"/> Elbow | <input type="checkbox"/> Head        | <input type="checkbox"/> Calf  | <input type="checkbox"/> Collar bone     |
| <input type="checkbox"/> Ear         | <input type="checkbox"/> Hamstring | <input type="checkbox"/> Thumb | <input type="checkbox"/> Mid Section |                                |  |
| <input type="checkbox"/> Other _____ |                                    |                                |                                      |                                |  |

**LACROSSE ACTIVITY:** (this accident)

**A) FIELD LACROSSE:**

Position played:       Forward                       Goal

This accident happened in the:  
 1st quarter       2<sup>nd</sup> quarter                       3<sup>rd</sup> quarter                       4<sup>th</sup> quarter

**B) BOX LACROSSE:**

Position played:       Middie       Attack       Defense       Goal Keeper

This accident happened in the:       1st period       2<sup>nd</sup> period       3<sup>rd</sup> period

**OTHER CONDITIONS:**

GAME PLAYED:                       Morning                       Afternoon                       Evening

WEATHER CONDITIONS:  Sunny                       Cloudy                       Rain  
 Other \_\_\_\_\_

TEMPERATURE - CELCIUS:  
 Below 0       0-10                       10-20                       20-25                       26-33                       plus 33

PLAYING SURFACE:  
 Wood       Grass       Concrete       Rubberized                       Artificial Turf  
 Other \_\_\_\_\_

LOCATION:  
 Gymnasium                       Community Centre                       Arena                       School

**HOW LONG HAS INDIVIDUAL BEEN ACTIVE IN LACROSSE:**

As a player \_\_\_\_\_ years      As a coach \_\_\_\_\_ years      As a referee \_\_\_\_\_ years

**WAS INJURED PERSON TREATED ON SITE OR REFERRED FOR PROFESSIONAL MEDICAL/DENTAL TREATMENT?**

On Site:  Yes  No

If "yes", treated by whom? \_\_\_\_\_  
Name

\_\_\_\_\_   
Position

Professional medical/dental treatment?  Yes  No

If "yes" Name of **Witness**: \_\_\_\_\_  
Full Address: \_\_\_\_\_

Phone Number: (    ) \_\_\_\_\_

\_\_\_\_\_  
**Submitted by (Signature)**

\_\_\_\_\_  
**Address**

\_\_\_\_\_  
**Position**

\_\_\_\_\_  
**Date**

**NOTE: IF MAJOR ACCIDENT, REQUIRE FULL WITNESS REPORTS AS WELL AS ALL OTHER REPORTS TO BE FORWARDED WITHIN TWENTY-FOUR (24) HOURS.**

Place an "X" at area of injury

Place an "O" at your net

Indicate if it was:

- Box Lacrosse
- Field Lacrosse

A large rectangular box for drawing the injury area. It contains two horizontal lines, one near the top and one near the bottom, serving as guides for placing an 'X' and an 'O' respectively.