



ACA Incident / Accident Report Form

DATE OF INCIDENT _____ TIME OF INCIDENT _____ AM/PM Name of Club: _____ Address: _____ Telephone Number: _____	DOES THE INJURED PERSON HAVE OTHER MEDICAL INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please provide name of company and policy #: _____
INJURED PERSON: <input type="checkbox"/> Athlete <input type="checkbox"/> Official <input type="checkbox"/> Coach <input type="checkbox"/> Spectator <input type="checkbox"/> Employee <input type="checkbox"/> Volunteer <input type="checkbox"/> Other _____ Was injured person a member of organization? <input type="checkbox"/> Yes <input type="checkbox"/> No	DID THIS TAKE PLACE DURING: <input type="checkbox"/> Practice <input type="checkbox"/> Competition <input type="checkbox"/> Club Activity/Event <input type="checkbox"/> Pre-activity <input type="checkbox"/> Sanctioned Activity/Event <input type="checkbox"/> After activity <input type="checkbox"/> While traveling

INJURED PERSON INFORMATION

Last Name _____ First _____ Middle _____	Telephone Number () _____	<input type="checkbox"/> Single <input type="checkbox"/> Married
Address _____		Social Security Number (optional) _____ Employer and Address _____
City _____ State _____ Zip _____		
Age _____	D.O.B. _____ <input type="checkbox"/> Male <input type="checkbox"/> Female	

GUARDIAN/PARENT (IF INJURED PERSON IS A MINOR)

Last Name _____ First _____ Middle _____	Telephone Number () _____
Address _____	City _____ State _____ Zip _____

SUSPECTED PRE-EXISTING CONDITION: ☐ Yes ☐ No

INCIDENT LOCATION <input type="checkbox"/> Competition area <input type="checkbox"/> Concession area <input type="checkbox"/> Parking lot <input type="checkbox"/> Admission area <input type="checkbox"/> Restrooms/locker rooms <input type="checkbox"/> Off property <input type="checkbox"/> Premises/grounds <input type="checkbox"/> Store area <input type="checkbox"/> Bleachers/stands CLASSIFICATION <input type="checkbox"/> Facility or event related <input type="checkbox"/> Non-injury <input type="checkbox"/> Not facility or event related <input type="checkbox"/> Minor injury or illness <input type="checkbox"/> Serious injury or illness	INCIDENT <input type="checkbox"/> Assault/Sexual <input type="checkbox"/> Slip, bodily reaction <input type="checkbox"/> Assault/Non-Sexual <input type="checkbox"/> Slip/Fall <input type="checkbox"/> Fall (different level) <input type="checkbox"/> Eligibility <input type="checkbox"/> Fall (same level) <input type="checkbox"/> Aquatic <input type="checkbox"/> Caught in, on, between <input type="checkbox"/> Trip/Fall <input type="checkbox"/> Animal/insect bite/sting <input type="checkbox"/> Drug Testing <input type="checkbox"/> Collision (with object) <input type="checkbox"/> Overexertion <input type="checkbox"/> Collision (participant/participant) <input type="checkbox"/> Collision (participant/spectator) <input type="checkbox"/> Collision (spectator/spectator) <input type="checkbox"/> Struck by falling/flying object <input type="checkbox"/> Auto/Property	MEDICAL SERVICES <input type="checkbox"/> Antacid <input type="checkbox"/> Eye rinse <input type="checkbox"/> Aspirin <input type="checkbox"/> Glucose <input type="checkbox"/> Aspirin substitute <input type="checkbox"/> Ice Pack <input type="checkbox"/> Bandaged <input type="checkbox"/> Oxygen <input type="checkbox"/> Ointment/antiseptic <input type="checkbox"/> Rest <input type="checkbox"/> Removal <input type="checkbox"/> Splinted <input type="checkbox"/> CPR <input type="checkbox"/> Wrapped <input type="checkbox"/> Cleansed <input type="checkbox"/> Exam <input type="checkbox"/> Cold Pack <input type="checkbox"/> None Treated By: _____
PRIMARY INJURY <input type="checkbox"/> Allergy <input type="checkbox"/> Dislocation <input type="checkbox"/> Nausea <input type="checkbox"/> Amputation <input type="checkbox"/> Electrical Shock <input type="checkbox"/> Stroke <input type="checkbox"/> Abrasion <input type="checkbox"/> Foreign Body <input type="checkbox"/> Burn <input type="checkbox"/> Laceration <input type="checkbox"/> Fracture <input type="checkbox"/> Death <input type="checkbox"/> Drowning <input type="checkbox"/> Heat Exhaustion <input type="checkbox"/> Pain <input type="checkbox"/> Hypertension <input type="checkbox"/> Cardiac <input type="checkbox"/> Illness <input type="checkbox"/> Cold Injury <input type="checkbox"/> Contusion <input type="checkbox"/> Sting/bite <input type="checkbox"/> Seizures <input type="checkbox"/> Concussion <input type="checkbox"/> Strain/Sprain <input type="checkbox"/> Tooth/Mouth	BODY PART INJURED <input type="checkbox"/> Eye (L/R) <input type="checkbox"/> Torso <input type="checkbox"/> Arm (L/R) <input type="checkbox"/> Nose <input type="checkbox"/> Back <input type="checkbox"/> Tooth <input type="checkbox"/> Neck <input type="checkbox"/> Face <input type="checkbox"/> Head <input type="checkbox"/> Ear (L/R) <input type="checkbox"/> Leg (L/R) <input type="checkbox"/> Knee (L/R) <input type="checkbox"/> Ankle (L/R) <input type="checkbox"/> Internal <input type="checkbox"/> Hip (L/R) <input type="checkbox"/> Shoulder (L/R) <input type="checkbox"/> Foot (L/R) <input type="checkbox"/> Elbow (L/R) <input type="checkbox"/> Hand (L/R) <input type="checkbox"/> Wrist (L/R) <input type="checkbox"/> Finger or Toe	DISPOSITION <input type="checkbox"/> Released to parent <input type="checkbox"/> Police <input type="checkbox"/> Refusal of care <input type="checkbox"/> Ambulance <input type="checkbox"/> Refer to doctor <input type="checkbox"/> Report only <input type="checkbox"/> Refer to hospital or clinic <input type="checkbox"/> Medical attention <input type="checkbox"/> EMS transport <input type="checkbox"/> Patient requested EMS transport <input type="checkbox"/> Released to personal vehicle

Describe how the incident occurred:

WITNESS INFORMATION

NAME	ADDRESS	TELEPHONE NUMBER
1.		()
2.		()
3.		()
4.		()
5.		()

Signature of Official (with no relationship to claimant) _____

Date: _____ Phone # _____

Send Completed Report to:

American Canoe Association (ACA)

PO Box 7996

Fredericksburg, VA 22401

Email: aca@americancanoe.org

Phone: (540) 907-4460

Activity organizers, trip leaders and trip coordinators must report all injuries requiring medical attention to the ACA National Office **within seven (7) days** using the ACA Incident / Accident Report Form. The report form must be accompanied by the original waiver of the injured party. In the event of a serious injury, **immediately notify the insurance company** (American Specialty) by calling 260-969-5203 or 800-566-7941. American Specialty will answer calls to this number 24 hours a day, 365 days a year (if calling after hours, follow the instructions for emergency claims reporting).