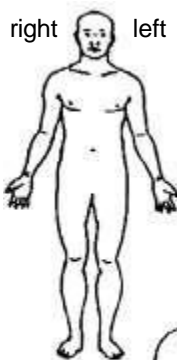
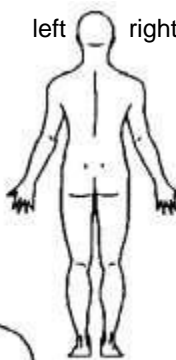



Northern Districts Gymnastic Club

INJURY REPORT FORM

To be filled immediately after the incident and submitted to the Competitive Programs Manager.

Injury Details: *This report reflects an accurate record of the patients' reported symptoms & signs of injury.*

Name of person injured:		DOB:	
Date when injury occurred: / /		Time of injury:	
Gymnastics Program: <input type="checkbox"/> ACR <input type="checkbox"/> AER <input type="checkbox"/> MAG <input type="checkbox"/> WAG <input type="checkbox"/> Recreation <input type="checkbox"/> Kindy <input type="checkbox"/> Holiday <input type="checkbox"/> Other			
Class Name:		Class time:	Supervising Coach:
Person injured: <input type="checkbox"/> Athlete <input type="checkbox"/> Coach <input type="checkbox"/> Other:		Gender: <input type="checkbox"/> M <input type="checkbox"/> F	
Where did the injury occur? <input type="checkbox"/> Training <input type="checkbox"/> Event <input type="checkbox"/> Other:		Reason for presentation: <input type="checkbox"/> New Injury <input type="checkbox"/> Recurrent Injury <input type="checkbox"/> Aggravated Injury <input type="checkbox"/> Other:	
Explain how the injury occurred:		Cause of injury: <input type="checkbox"/> Collision with fixed object <input type="checkbox"/> Collision with another person <input type="checkbox"/> Fall from height / awkward landing <input type="checkbox"/> Slip / trip / fall / stumble <input type="checkbox"/> Other:	
Signs/Symptoms / Nature of injury:			
<input type="checkbox"/> Blisters <input type="checkbox"/> Bloody Nose <input type="checkbox"/> Bruising/Contusion <input type="checkbox"/> Burn <input type="checkbox"/> Cut/Laceration <input type="checkbox"/> Discolouration <input type="checkbox"/> Dislocation/Subluxation <input type="checkbox"/> Graze/Abrasion		<input type="checkbox"/> Inflammation /Swelling <input type="checkbox"/> Insect Bite/Sting <input type="checkbox"/> Loss of consciousness <input type="checkbox"/> Open wound/laceration <input type="checkbox"/> Pain (<i>if yes, how much pain></i>) <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Tenderness <input type="checkbox"/> Heavy bleeding	
		<input type="checkbox"/> Concussion <input type="checkbox"/> Suspected fracture <input type="checkbox"/> Overuse <input type="checkbox"/> Other:	
Body part injured: <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;"> right  </div> <div style="text-align: center;"> left  </div> </div> <div style="text-align: center; margin-top: 20px;">  </div>		Initial Treatment: <input type="checkbox"/> No Treatment required <input type="checkbox"/> Ice <input type="checkbox"/> Rest <input type="checkbox"/> Sling <input type="checkbox"/> Splint <input type="checkbox"/> Dressing	
		Describe Treatment provided / Action taken: 	
		Was protective equipment worn on the injured site? <input type="checkbox"/> Yes <input type="checkbox"/> No e.g. hand guard, footwear	
Witness:		Disposition: <input type="checkbox"/> Return to class <input type="checkbox"/> Left with parent <input type="checkbox"/> Ambulance <input type="checkbox"/> Other:	
Printed name of person completing form: _____		Referral: <input type="checkbox"/> No Referral <input type="checkbox"/> Medical Practitioner <input type="checkbox"/> Hospital <input type="checkbox"/> Other:	
Signature: _____		Date: / /	

Note: This document is prepared for the sole purpose of pertaining legal advice. Coaches without medical training should refer all medical decisions to appropriately qualified persons. Users of this form are advised that medical information should be treated confidentially, in-line with Commonwealth Privacy Act 1998. Be advised additional legislation affects the management of health records in some states. i.e. Victoria has legislation defining the use of Health Records (Health Records Act 2001). Search on <http://www.austlii.edu.au>. Send a copy of this report to the insurer within the policy period. Coaches can refer to the Risk Management Policy to manage risks associated with coaching.



Northern Districts Gymnastic Club

INJURY REPORT FORM

INJURY FOLLOW-UP

Coach Review:

Signature: _____ Date: _____

Competitive Programs Manager Review:

Signature: _____ Date: _____

General Manager Review:

Signature: _____ Date: _____

Actions to take:

Signature: _____ Date: _____

Document title: Injury Report Form
Responsible Officer/Department: Human Resources & Child Safety
Date of last review: November 2021 **Date of next review:** June 2022