



ACCIDENT REPORT
Developed by A.C.A.

Submit to: Girl Scouts of Utah, 445 East 4500 South Suite 125, Salt Lake City, Utah 840107

Camp/Event/Trip name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

Name of injured \_\_\_\_\_ Age \_\_\_\_ Sex \_\_\_\_\_

Camper/Girl Staff/Volunteer Visitor/Non-registered Girl Scout

Address of person injured \_\_\_\_\_

If minor, name of parent/guardian \_\_\_\_\_

Address of parent/guardian \_\_\_\_\_

Names/addresses of witnesses (attach signed statement as to incident)

- 1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Date of accident \_\_\_\_\_ Hour \_\_\_\_\_ a.m. p.m.

Where did accident occur? (Specify location, including location of injured and witnesses. Use diagram to locate persons and objects.)

Describe accident in detail.

Was the injured participating in an activity at the time of the injury? Yes No

If so, what? \_\_\_\_\_

Any equipment involved in accident? \_\_\_\_\_

What could have been done to prevent the injury? \_\_\_\_\_

Emergency procedures followed at time of accident: \_\_\_\_\_

\_\_\_\_\_

By whom? \_\_\_\_\_

Submitted by \_\_\_\_\_ Position \_\_\_\_\_ Date \_\_\_\_\_

## Medical Report of Accident

Were parents notified?  Yes  No  In writing  By phone  Other \_\_\_\_\_

By whom? \_\_\_\_\_ When? \_\_\_\_\_

Where was treatment given?

Camp  Camp health service  Doctor's office  Hospital  Program Venue/Location

Treatment given at camp?  Yes  No Where? \_\_\_\_\_

By whom? \_\_\_\_\_ Date \_\_\_\_\_

Treatment given: \_\_\_\_\_

Was injured admitted to camp health service?  Yes  No If so, when? \_\_\_\_\_

Treatment given: \_\_\_\_\_

Date released from health service: \_\_\_\_\_

Released to:  camp activities  home  other \_\_\_\_\_

Treatment given elsewhere than camp?  Yes  No Where? \_\_\_\_\_

By whom? \_\_\_\_\_ Date \_\_\_\_\_

Was injured admitted to hospital?  Yes  No If so, which? \_\_\_\_\_

Where? \_\_\_\_\_ Date \_\_\_\_\_  Out-patient  In-patient

Name of physician in attendance \_\_\_\_\_

Date released from hospital \_\_\_\_\_

Released to:  Camp  Health service  Home  Volunteer/Staff  Other \_\_\_\_\_

Comments:

Signed \_\_\_\_\_ Position \_\_\_\_\_ Date \_\_\_\_\_

Insurance claim/report submitted:

Date

1. \_\_\_ Parent's Insurance  By parent  By camp \_\_\_\_\_

2. \_\_\_ Camp Health Insurance \_\_\_\_\_

3. \_\_\_ Workman's Compensation \_\_\_\_\_

4. \_\_\_ Camp Liability Insurance \_\_\_\_\_