

Central Florida Council BSA Accident/Incident Report Form
(fax to Council Risk Management Committee at (352)669-8558)

Unit/ Camp Name _____ Date _____

Address _____
Street & Number City State Zip

Name of person involved _____ Age _____ Sex _____ Camper Staff Visitor
Last First Middle

Address _____ Phone _____
Street & Number City State Zip Area/Number

Name of Parent/Guardian (if minor) _____

Address _____ Phone _____
Street & Number City State Zip Area/Number

Name/Address of Witnesses (You may wish to attach signed statements.)

1. _____
2. _____
3. _____

Type of incident Behavioral Accident Epidemic Illness Other (describe)

Date of Incident/Accident _____ Hour _____ a.m. p.m.

Describe the sequence of activity in detail including what the (injured) person was doing at the time _____

Where occurred? (Specify location, including location of injured and witnesses. Use diagram to locate persons/objects.)

Was injured participating in an activity at time of injury? Yes No If so, what activity? _____

Any Equipment involved in accident? Yes No If so, what kind? _____

What could the injured have done to prevent injury? _____

Emergency procedures followed at time of incident/accident _____

By Whom? _____

Submitted by _____ Position _____ Date _____

Phone number _____

Medical Report of Accident

Were parents notified? Yes No By Writing Phone Other _____

By whom? _____ Title _____ When _____
Time _____ Date _____

Parent's Response _____

Where was treatment given (check and complete all that apply)?

At Accident Site: Where? _____ By whom? _____
Treatment given _____

Camp health Service: By whom? _____ Title _____
Treatment given _____
Released to Camp Activities Home Other _____

Doctor's Office: By whom? _____ Title _____
Treatment given _____
Released to Camp Activities Camp Health Service Home Other _____

Hospital: By whom? _____ Title _____
Was injured retained overnight in hospital? Yes No If so, which? _____
Where? _____ Date _____ Out-patient In-patient
Name of physician in attendance _____
Date released from hospital? _____
Released to Camp Home Other _____

Comments _____

Persons notified such as camp owner/sponsor, board of directors, etc.

Name	Position	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe any contact made with/by the media regarding this situation _____

Signed _____ Position _____ Date _____

Insurance Notification

	By <input type="checkbox"/> Parent <input type="checkbox"/> Camp	Date
1. <input type="checkbox"/> Parent's Insurance	_____	_____
2. <input type="checkbox"/> Unit Accident Insurance	_____	_____
3. <input type="checkbox"/> Worker's Compensation	_____	_____
4. <input type="checkbox"/> Camp Liability Insurance	_____	_____