ACCIDENT REPORT

DATE: _____________________________

TIME: ______________________________

EVENT/LOCATION: _____________________________________________________

ATHLETE’S NAME: _____________________________________________________

ATHLETE’S TEAM NAME: ________________________________________________

WITNESS NAME: _______________________________________________________

DESCRIPTION OF ACCIDENT/INJURY: _______________________________________

_______________________________________________________________________

_______________________________________________________________________

TREATMENT REQUIRED: _________________________________________________

_______________________________________________________________________

WHO ADMINISTERED: ___________________________________________________

SIGN BY WITNESS: _____________________________________________________

SIGNED BY COACH: ____________________________________________________

DATE: _________________________________

*Please complete this form in case of sickness or injury and return it to any GMT Member or SOKS staff person.

MAIL FORM TO: Special Olympics Kansas
5280 Foxridge Dr
Mission, KS 66202