ACCIDENT REPORT

DATE: ______________________________

TIME: ______________________________

EVENT/LOCATION: ____

ATHLETE'S NAME: ____

ATHLETE'S TEAM NAME: ____

WITNESS NAME: ____

DESCRIPTION OF ACCIDENT/INJURY: _____________________________________

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TREATMENT REQUIRED: ____

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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