

Seneca Valley Junior Football Association

of Cranberry Township

P.O. Box 1638
Cranberry Township, PA 16066
www.svjfootball.org



SVJFAC Injury Incident Report

Updated: 7/15/2005

This form must be completed within two days of any incident that resulted in the injury to any player, coach, fan, or other individuals involved in an Seneca Valley Junior Football Association of Cranberry Township event when that injury requires, or is expected to require professional medical attention such as emergency room treatment or treatment by a family physician or specialist. The form must be filled out by an association recognized member of the team's coaching staff, Team Parent, or board member who was in attendance at the time of incident. If additional space is needed, please add another sheet.

The head coach must acknowledge the incident through their signature, if the incident occurred during a team function. The program coordinator must sign the document if the incident occurred during an event prior to the formation of teams or the course of a general association event involving their program. The senior board member present must sign the document in the event the incident occurred during a general association event.

Upon completion, the form must be presented to the program coordinator who is to retain a copy with their files and a copy to the Facilities Coordinator, with notification to the association President within three days of the incident.

Information to be documented:

Date of Incident:	Time of Incident
Injured individual; Name, Age, Team affiliation	
Location of Incident:	
Activity Taking Place: (game, practice, pre or post practice, party, competition, tryouts, etc.)	
Describe Incident: (drill, play, stunt, situation)	
Provide other relevant information: (weather, field conditions, etc.)	
Activity Leadership Present & Role/Title (coaches, officials, teen helpers)	
Other Adults Present who may have observed incident:	
Proactive Action Taken as Precautionary Measure:	
Action Taken to address injury & by Whom:	
Transportation to healthcare facility provided by:	
Professional Medical Treatment Provided by: Physician and/or Institution	
Date of Physician Care:	
Outcome of physician examination:	
Physician's treatment and direction for recovery:	
In case of child, date of projected return to full participation:	
Coach's or Board Follow-up w/ Family:	

Person Completing Form: _____ Date: _____

Head Coach or Board Member: _____ Date: _____

Program Coordinator: _____ Date: _____

Facilities Coordinator: _____ Date: _____

President: _____ Date: _____