PERTH NETBALL ASSOCIATION INCORPORATED

PERTH NETBALL ASSOCIATION (INC)

Injury Report

To be completed by the injured person or witness. This form should be completed and forwarded to the Match Day Office on the same day the injury occurs. **Serious accidents and/or injury should be reported immediately to the First Aid Room attendant or Official in the Match Day Office.**

Did the injured party get injured whilst playing on a SGV or CFV? Yes / No

Name of Injured Party:								
Age:		Date of Birth:	/ /			Sex:		
Address:								
Home Phone:			Mobile:					
Signature: If under the age of 18 parent/guardian to sign.								
Status of Injured Person:	Player	Official	Coach	Admin Staff	Spectator	Visitor	Umpire	Parent/ Guardian
Date of Injury:	/ /			Time:				
When Injury Occurred:	Game Day	Training	Carnival	PNA Trials	PNA Clinic			
Where Injury Occurred:	Court #	Court Side #	Club Cages	Admin Building	Kiosk	Hall/ Boardroom		
	Other:							
Is this Player subject to PNA Concussion Policy? Yes / No				Match Day Office Notified? Yes / No				
Describe how the injury occurred:								
Part of the body injured:								
Description of the injury:								

Is this a pre-existing injury/condition? Yes / No (If yes please advise on the following 3 questions)

	Are you receiving or have had any medical treatment for this pre-existing injury/condition? Yes / No
	Are you currently taking any medication for this injury? Yes / No
	Please advise the name & number of practitioner treating the injury:

Reportee / Witness Details

Reportee Name:		Witness Name:	
Position Held:		Position Held:	
Club/School:		Club/School:	
Phone:		Phone:	

First Aid Administered at Site of Incident

Administered By:		Phone Mobile:		Phone Work:	

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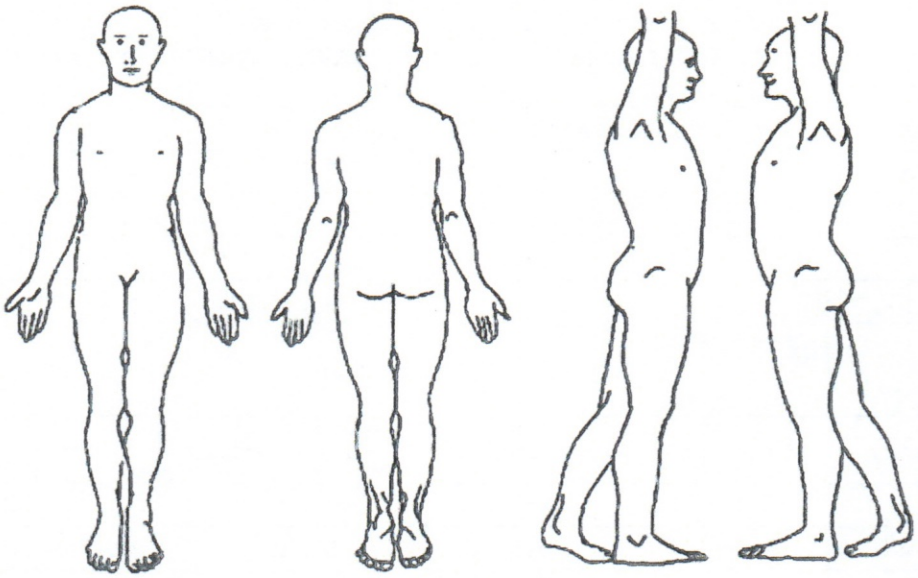
Please circle the description which best describes your status:							
Player	Official	Coach	Admin Staff	Spectator	Umpire	Parent/ Guardian	Other:

FIRST AID OFFICE USE ONLY

To be completed by the First Aid / Physiotherapy Personnel

BODY CHART



Treatment:	RICER (Rest, Ice, Compression, Elevation)	Tape/Bandage	Wound Dressing	Other:

Provisional Diagnosis:

Recommendations:	Referral for X-Ray	Referral for DR / Hospital	Advice on Home Management & Return to Sport	Other:

Was an ambulance required? Yes / No	Did the person lose consciousness at any time: Yes / No
Treatment Administered By:	Position:
Signature:	Date: / /
	Time:

Complete only if injured person refused treatment

Did the injured person refuse treatment? Yes / No	Date: / /	Time:	
Signature: If under the age of 18 parent/guardian to sign.		Signature of Trainer / Physiotherapist:	

OFFICE USE ONLY

Club Co-ordinator notified of concussion	*Sent By:*		*Date:*	/ /
Medical clearance received	*Received By:*		*Date:*	/ /