girl scouts of eastern pennsylvania

GIRL SCOUTS OF EASTERN PENNSYLVANIA
INCIDENT/ACCIDENT REPORT

Please email signed form to humanres@gsep.org or return to a Service Center.

Name of person involved:

Address:

City: State: Zip:

Phone: Age: Sex:

❒ Girl - Troop Number: ❒ Staff ❒ Volunteer ❒ Other

Name of Parent/Guardian (if minor):

Address:

City: State: Zip:

Date of Incident (XX/XX/XXXX): Time: ❒ A.M. ❒ P.M.

Name of facility where incident/accident took place:

Name and address of witness(es). (You may wish to attach signed statements.)

1. Witness Name:

Address: City: State: Zip:

2. Witness Name:

Address: City: State: Zip:

3. Witness Name:

Address: City: State: Zip:

Type of incident: ❒ Behavioral ❒ Accident ❒ Illness ❒ Other (describe):

List any injuries:

Describe the sequence of activity in detail including what the person was doing at the time of the incident/accident:

Where did the incident/accident occur? (specific location – draw diagram to show location of persons/objects):

Was individual participating in an activity at time of the incident/accident? ❒ Yes ❒ No

If yes, what activity?

Any equipment involved in incident/accident? ❒ Yes ❒ No If yes, what type?

Condition of equipment:

Emergency procedures followed at time of incident/accident:

By whom:

Report submitted by: Date:

Position: Phone:

Address: City: State: Zip:

OVER ➔

MEDICAL REPORT OF ACCIDENT

How much time lapsed between injury and First Aid?

Were parents notified? ❑ Yes ❑ No By: ❑ Writing ❑ Phone ❑ Other:

By whom: Title:

Date of Notification: Time of Notification: ❑ A.M. ❑ P.M.

Parent's response:

Where was treatment given? ❑ At Accident Site ❑ Doctor's Office ❑ Hospital

By whom:

Date of Treatment: Time of Notification: ❑ A.M. ❑ P.M.

Describe treatment given:

Was injured person admitted overnight in a hospital? ❑ Yes ❑ No If so, what Time: ❑ A.M. ❑ P.M.

Name of hospital:

If hospitalized, how was injured person transported? ❑ Council Vehicle ❑ Volunteer Vehicle ❑ Ambulance

Attending physician's name:

Date released from hospital: Time released from hospital: ❑ A.M. ❑ P.M.

Released to: ❑ Volunteers ❑ Parents ❑ Other:

Comments about incident/accident:

Persons notified such as Girl Scout Executive Director, staff member, etc.:

Name Date

Position

If applicable, describe any comments to the media regarding this situation and by whom:

Signature of Person Submitting This Report:

FOR COUNCIL USE ONLY:

INSURANCE NOTIFICATION:	BY WHOM:	DATE:
1. ❑ Worker's Compensation		
2. ❑ General Liability Insurance		
3. ❑ Automobile Insurance		
4. ❑ United of Omaha		
5. ❑ OTHER:		

NOTE: ANY DOCUMENTATION, ETC. SHOULD BE INITIALED, DATED AND ATTACHED TO THIS FORM