Faith In Practice
Volunteer Incident Report

Date: _____ Time incident occurred: _____ Location of Incident: _____

Name of involved party: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (H): _____ (W) _____

Name of witness: _____ Phone (H): _____ (W)_____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: (H) _____ (W) _____

Loss of conscious ☐ Yes ☐ No Age: _____ Male ☐ Female ☐

Team # _____ Mission Coordinator Name _____

Nature of Complaint (*Mark as appropriate*):

- ☐ **A**thletic Injury
- ☐ Allergic Reaction
- ☐ Anxiety Reaction
- ☐ Asthma/Respiratory trouble
- ☐ **B**ehavior Crisis
- ☐ Bite/Sting
- ☐ Broken Bone
- ☐ Bruise
- ☐ Burn
- ☐ **C**ardiac Incident
- ☐ Choking/Aspiration
- ☐ Cut
- ☐ **D**iabetic Patient
- ☐ Dizziness
- ☐ **E**ye Injury
- ☐ **F**ainting
- ☐ Fall
- ☐ **H**eadache
- ☐ Head or Neck Injury
- ☐ Heat Exhaustion
- ☐ **O**verexertion
- ☐ **P**edestrian Accident
- ☐ **S**eizure
- ☐ Smashed Digit
- ☐ Sprain
- ☐ **U**nknown
- ☐ **V**ehicle Accident
- ☐ Other: _____

Detailed description of incident and response:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

(Continue on next page)

Detailed description of incident *(continued from previous page):*

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Medical History: _____
_____
_____

First Aid Administered *(Mark as appropriate)*:

☐ CPR
☐ Fast Sugar Source
☐ Irrigation
☐ Bandage
☐ Cool Pack
☐ Wrap
☐ Water
☐ Clean (soap & water or peroxide)
☐ Other: _____

Deposition of Injured Party

☐ Admitted to hospital or visited clinic _____

☐ Treated by team physician

☐ Emergency Air-lift (Location) _____

☐ Transported to hospital in US (city) _____

☐ Refused Care _____ Date_____
Signature

_____
Explanation

☐ Other: _____
_____

Who accompanied to hospital: _____

Signature of involved party: _____

Team Leader signature : _____ Date: _____