DELAWARE VALLEY YOUTH SOCCER CLUB

INJURY REPORT FORM

This form must be completed for all injuries occurring at an official DVYSC Soccer Event and requiring an evaluation by a Physician or Health Practitioner (911 is called, player taken to hospital/clinic, concussion suspected). A Team Official (Coach or Assistant Coach) who witnessed the incident must complete this form and submit it to the DVYSC President within 24 hours at pres.dvysc@gmail.com. If an insurance claim needs to be made through NJYS, please direct the parents/guardian to reach out to the DVYSC President.

☐ If the individual sustained a concussion injury outside of an official DVYSC Soccer Event and is currently in concussion protocol under the treatment of a healthcare professional, please check this box and complete the relevant sections of this form. The individual is not cleared to return to official events until cleared by their healthcare professional. The individual is not eligible for and insurance claim through NJYS.

Individual (circle one): Coach Player Other: ______________________

Individual's Full Name: ______________________ DOB: __________

Address: ____

City: ________________ State: ______ Zip: __________

Date of Incident: ________________ Time: ______ AM PM

Event (circle one): Game Practice Other: ______________________

Location of Injury (Town, Field Location, Field Number, etc.): ______________________

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Description of Injury: ____

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Description of Incident (How did the injury occur): ______________________

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Emergency Medical Services Called (circle one)? YES NO

Hospital / Clinic Where Player Transported: ______________________

Mode of Transportation: ______________________________________

Parent / Guardian of Individual: ______________________ Notified: Yes No

Name of Individual Completing this form: ________________ Phone: __________

Signature: ________________ Date: __________