



.....**ACCIDENT REPORT FORM**

Date of incident: _____

Time: _____

Name of injured person: _____

Address: _____

Phone Number(s): _____

Date of birth: _____ Male Female

Who was injured party? Youth Participant Volunteer/Employee

Type of injury: _____

Details of incident: _____

Injury requires physician/hospital visit? Yes No * (if no, please sign below)

Name of physician/hospital: _____

Address: _____

Physician/hospital phone number: _____

Signature of injured party /guardian _____

Date

***No medical attention was desired and/or required.**

Signature of injured party/guardian _____

Date

Club Name _____

Where did Incident occur?: _____

Was this a 4-H sanctioned event? Yes No

Has the 4-H Club Leader been notified? Yes No

Return this form to 4-H County Extension Office within 24 hours of incident.