



Minor Injury Log

Program/Group Name: _____

Program Leader(s): _____ Season/Year: _____

Instructions

- Administer necessary first aid.
- Document minor injuries. Utilize PDRMA Form 01 for more serious injuries and PDRMA Form 04 for serious employee related injuries.
- Notify guardian upon dismissal from the program.

Date (eg. 7/19/19)	Time (eg. 11:30a)	Name of Injured (Full Name)	Injury Location (eg. right elbow)	Treatment (eg. rinse & ice pack)	How injury occurred (eg. fell off swing)	Facility/Location where injury occurred (eg. Harmony Park swing)	Full Name of staff who notified guardian

Submit form to Operations Manager at the end of the program season.

Location: <S:\1- Office Forms\Safety Forms\Accident&Incident\Minor Injury Log.pdf>

Updated 8/16/2019

Minor Injury Log

Date (eg.7/19/19)	Time (eg.11:30a)	Name of Injured (Full Name)	Injury Location (eg. right elbow)	Treatment (eg. rinse & ice pack)	How injury occurred (eg. fell off swing)	Facility/Location where injury occurred (eg. Harmony Park swing)	Full Name of staff who notified guardian

1	Agency name	Today's date		
2	Date of incident (mm/dd/yyyy)	Time of incident (hh/mm a.m./p.m.)		
3	Name of person completing report	Title of person completing report		
4	Business phone number	Business email		
5	How did the incident occur? (Provide a brief, factual description; do not speculate on fault, etc.)			
6	Name of the location (park, pool, community center; <i>Ex. Smith Pool, Johnson Community Center</i>) or nearest intersection where the incident occurred.			
7	Is there an address for this location? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
	If yes, please provide the following:			
	Street address _____			
	City _____	State _____	Zip code _____	
8	Location (Specify the exact type of location/facility where injury occurred. <i>Ex. maintenance garage, sports field, aquatic outdoor, golf course, etc.</i>)			
9	Primary location (Specify exact location. <i>Ex. lap pool, cart storage, classroom, pavilion</i>)			

BODILY INJURY

If an employee was injured, please submit the form for an Employee Injury (Form 04) type of incident.

10	Was a person injured? (<i>Ex. patron, citizen, participant, volunteer</i>)			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
11	If yes, please provide the following information:			
	Last name _____		First name _____	
	Address _____			
	City _____	State _____	Zip code _____	
	Home phone # _____	Work phone # _____	Cell phone # _____	
	Age _____	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		
12	Is injured person an agency volunteer?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
13	Describe the injury (affected body part and type of injury; <i>Ex. contusion, bruise, laceration, sprain, break, etc.</i>)			
14	Did injured person make any statements?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
	If yes, what did injured person say? _____			

15 Was first aid administered? ☐ Yes ☐ No ☐ Unknown

Name and position of person who administered first aid _____

What first aid was given? _____

Did first aid involve AED and/or CPR? ☐ Yes ☐ No ☐ Unknown

If yes, please submit a PDRMA post-AED form.

Were paramedic services offered?

Called and refused (at scene by patron) ☐ Yes ☐ No ☐ Unknown Offered and called ☐ Yes

Offered and refused ☐ Yes ☐ No ☐ Unknown Offered, refused, called by agency anyway ☐ Yes

Unable to respond and called ☐ Yes ☐ No ☐ Unknown

Were police called? ☐ Yes ☐ No ☐ Unknown If yes, please provide the following information.

Name of police department _____

Name of officer _____

Do you expect this person to submit a claim? ☐ Yes ☐ No ☐ Unknown

PROPERTY DAMAGE

16 Was property damaged as a result of this accident/incident? ☐ Yes ☐ No ☐ Unknown

17 If yes, how was the person involved in the accident/incident?

Owner of property adjacent to park district ☐ Patron ☐

Vehicle owner ☐ Other ☐

18 Last name (or business name) _____ First name (not necessary if business name) _____

Address _____

City _____ State _____ Zip code _____ Phone number _____

Describe the property damage _____

WITNESS INFORMATION

19 If there was a witness(es) to the accident/incident, please provide the following information:

Last name _____ First name _____

Address _____

City _____ State _____ Zip code _____ Phone number _____

20 Did witness make any statements? ☐ Yes ☐ No ☐ Unknown

If yes, what did witness say? _____

21 Where was witness when the accident/incident occurred? _____



Vehicle Accident Report

(Accident involving agency vehicle. May involve bodily injury/property damage.)

Attorney/Client Privileged Document

Form

02

1	Agency name	Today's date		
2	Date of incident (mm/dd/yyyy)	Time of incident (hh/mm, a.m./p.m.)		
3	Name of person completing the report	Title of person completing report		
4	Business phone	Business email		
5	How did the incident occur? (Provide a brief factual summary.)			
6	Name of the location (street/road/highway) or nearest intersection where the incident occurred.			
7	Is there an address for incident location? If yes, please provide the following:			
	Street address			
	City	State	Zip code	
8	Location			
	Offsite (non-agency owned)	[]	On agency property	[]
9	Primary location			
	Highway/roadway	[]	Parking lot	[]
			Other	[]
10	Was the agency vehicle occupied? [] Yes [] No [] Unknown			
11	Agency driver last name		First name	
	Address			
	City	State	Zip code	
	Home phone #		Work phone #	Cell phone #
	Email			
	Is this driver an employee? [] Yes [] No [] Unknown			
	If Yes, enter job title of employee			
	Identify the type of driver			
	Full-time employee	[]	Intern	[]
	Part-time employee	[]	Volunteer	[]
	Seasonal employee	[]	Non-agency employee	[]
			Spouse/family member	[]
12	Agency vehicle VIN	Make	Model	License number

13	Is vehicle drivable?	[] Yes	[] No	[] Unknown
	If no, provide current location of vehicle			
14	Area of damage			
15	Estimated repair cost			
16	Was a trailer involved?	[] Yes	[] No	[] Unknown
	If yes, provide the following information.			
	Trailer year	Make	Model	License number
	Trailer area of damage			
	Current location of trailer			
	Estimated repair cost of trailer			
17	Has a police agency conducted an investigation?	[] Yes	[] No	If yes, provide the following information.
	What police agency investigated the incident?			
	Police report number			
18	Was the agency driver ticketed, arrested or cited for violation(s)?	[] Yes	[] No	[] Unknown
	If yes, provide details of the ticket, arrest or violation(s).			
19	CLAIMANT INFORMATION			
	Identify other people involved in the accident. <i>(Make additional copies of this section if needed.)</i>			
	How was the person involved in the accident? <i>(Check all that apply.)</i>			
	Driver of other vehicle []	Injured person []	Owner of involved property []	
	Owner of other vehicle []	Passenger of agency vehicle []	Passenger of other vehicle []	
	Pedestrian []			
	Last name or business name		First name (not necessary for business)	
	Address			
	City	State	Zip code	
	Home phone #	Work phone #	Cell phone #	



Vehicle Accident Report

(Accident involving agency vehicle. May involve bodily injury/property damage.)

Attorney/Client Privileged Document

Form
02
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19	Vehicle make	Model	Year
Area of damage			
Is vehicle driveable? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, current location of vehicle			
Extent of damage <input type="checkbox"/> Moderate <input type="checkbox"/> Nothing visible <input type="checkbox"/> Severe <input type="checkbox"/> Slight			
Describe the property damage (<i>other than vehicle</i>)			
Extent of damage to property other than vehicle <input type="checkbox"/> Moderate <input type="checkbox"/> Nothing visible <input type="checkbox"/> Severe <input type="checkbox"/> Slight			
Age of injured person _____		Sex of injured person	<input type="checkbox"/> Male <input type="checkbox"/> Female
Was the injured person transported by paramedics?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, where was the injured person taken?			
Do you expect the injured person to file a claim?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Describe the injury			

ADDITIONAL CLAIMANT INFORMATION

Identify other people involved in the accident. (*Make additional copies of this section if needed.*)

How was the person involved in the accident? (*Check all that apply.*)

Driver of other vehicle <input type="checkbox"/>	Injured person <input type="checkbox"/>	Owner of involved property <input type="checkbox"/>
Owner of other vehicle <input type="checkbox"/>	Passenger of agency vehicle <input type="checkbox"/>	Passenger of other vehicle <input type="checkbox"/>
Pedestrian <input type="checkbox"/>		

Last name or business name

First name (not necessary for business)

Address

City

State

Zip code

Home phone #

Work phone #

Cell phone #

Vehicle make

Model

Year

Area of damage

Is vehicle driveable? ☐ Yes ☐ No If no, current location of vehicle

Extent of damage ☐ Moderate ☐ Nothing visible ☐ Severe ☐ Slight

Describe the property damage (*other than vehicle*)

Extent of damage to property other than vehicle ☐ Moderate ☐ Nothing visible ☐ Severe ☐ Slight

19	Age of injured person _____	Sex of injured person	<input type="checkbox"/> Male	<input type="checkbox"/> Female
	Was the injured person transported by paramedics?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	If yes, where was the injured person taken?			
	Do you expect the injured person to file a claim?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Describe the injury			

20	Identify witnesses of the accident. (Provide the following information for each witness. Make additional copies of this page if needed.)			
	Last name		First name	
	Address			
	City	State	Zip code	
	Home phone #	Work phone #	Cell phone #	
	Witness to accident? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, provide the following information.			
	Relation to injured person or property owner:			
	Agency employee or volunteer <input type="checkbox"/>	Another program participant or park user <input type="checkbox"/>	Friend <input type="checkbox"/>	
	Other <input type="checkbox"/>	Passerby <input type="checkbox"/>	Relative <input type="checkbox"/>	
	Did witness make any statements? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
	If yes, provide the following information.			
	What did witness say?			
	Where was witness when the accident occurred?			

21	Was the driver of the agency vehicle conducting agency business at the time of the accident?			
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
22	What street was the agency driver on?		What street was the other driver driving on?	
23	What direction was the agency driver traveling?	<input type="checkbox"/> North	<input type="checkbox"/> South	<input type="checkbox"/> East <input type="checkbox"/> West
	What direction was the other driver traveling?	<input type="checkbox"/> North	<input type="checkbox"/> South	<input type="checkbox"/> East <input type="checkbox"/> West
24	Weather conditions			
	Dry <input type="checkbox"/>	Fog <input type="checkbox"/>	Ice <input type="checkbox"/>	Snow <input type="checkbox"/> Wet <input type="checkbox"/>
25	Accident diagram			
	<div></div>			

Property Loss Report

(For damage to agency property)

Attorney/Client Privileged Document

Form

03

1	Agency name	Today's date		
2	Date of incident (mm/dd/yyyy)	Time of incident (hh/mm, a.m./p.m.)		
3	Name of person completing the report	Title of person completing report		
4	Business phone	Business email		
5	How did the incident occur and what property was damaged? (Provide a brief factual summary.)			
6	Name of the location (park, pool, community center; <i>Ex. Smith Pool, Johnson Community Center</i>) or nearest intersection where the incident occurred.			
7	Is there an address for incident location? If yes, please provide the following:			
	Street address			
	City	State	Zip code	
8	Location (Specify the exact type of location/facility damaged, listing multiple locations/facilities if necessary. <i>Ex. maintenance garage, sports field</i>)			
9	Primary location (Identify the exact area of damage. <i>Ex. tool storage, batting cage</i>)			
10	Estimate of loss			
11	Contact person at facility			
12	Contact person's email			
13	Contact person's phone number			
14	Was damage caused by third-party (non-agency) individual? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
15	Has the party responsible for damage been identified? If yes, provide the following contact information for the person or persons identified:			
	Name	Street address		
	City	State	Zip code	
16	Has a police agency conducted an investigation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
17	What police agency investigated the incident?		What is the police report number?	
18	Were criminal charges brought against the responsible party? If yes, what were the charges?			

1	Complete an Employee Injury Report for each employee injured.		
2	Agency name	Today's date	
3	Date of incident (mm/dd/yyyy)	Time of incident (hh/mm a.m./p.m.)	
4	Name of person completing report	Title of person completing report	
5	Business phone	Business email	
6	How did the incident occur? (Provide a one-line factual description.)		
7	Name of the location (park, pool, community center; <i>Ex. Smith Pool, Johnson Community Center</i>) or nearest intersection where the incident occurred.		
8	Is there an address for this location? If yes, please provide the following:		
	Street address		
	City	State	Zip code
9	Location (Specify the exact type of location/facility where injury occurred. <i>Ex. maintenance garage, sports field, aquatic outdoor, golf course, etc.</i>)		
10	Primary location (Specify exact location. <i>Ex. lap pool, cart storage, classroom, pavilion</i>)		
11	Employer's FEIN		
12	Did the employee miss more than three (3) scheduled workdays?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Unknown
13	What was the employee doing when the accident occurred?		
14	How did the incident occur? (Provide a detailed factual description.)		
15	Employee last name	First name	
	Address		
	City	State	Zip code
	Home phone #	Work phone #	Cell phone #
	Best number to contact employee	Email	
	Social security number	Date of birth (mm/dd/yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
	Marital status (divorced/married/single/unknown)	Number of dependents	Does employee speak English? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Average weekly wage	Job title/occupation	

Employee Injury Report

Form
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15	What is the employee's employment status?			
	<input type="checkbox"/> Permanent full-time	<input type="checkbox"/> Permanent part-time	<input type="checkbox"/> Seasonal	<input type="checkbox"/> Intern <input type="checkbox"/> Other
	Date hired (mm/dd/yyyy)	What is the employee's tenure? (length of employment)		
		<input type="checkbox"/> Less than 1 yr. <input type="checkbox"/> 1-3 yrs. <input type="checkbox"/> 4-10 yrs. <input type="checkbox"/> 11-19 yrs. <input type="checkbox"/> More than 20 yrs.		
	Time employee began work on day of incident (hh/mm a.m./p.m.)			
	Last date employee worked prior to date of incident (mm/dd/yyyy)			
	If the employee died as a result of the accident, give the date of death. (mm/dd/yyyy)			
	Did the incident occur on agency premises? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
	Injury or illness? <input type="checkbox"/> Injury <input type="checkbox"/> Illness			
	Describe the injury or illness (affected body part and type of injury; <i>Ex. contusion, bruise, laceration, sprain, break, etc.</i>)			
	What object or substance, if any, directly harmed the employee?			
	16	Did the injured employee seek medical attention?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
17	If yes, was the treatment given away from the worksite?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
18	Was the employee treated in an emergency room?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19	Was the employee hospitalized overnight as an inpatient?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
20	Name of treating physician, health care provider, or emergency room			
	Address			
	City	State	Zip code	
	Phone number			

1	Employee name.		
2	Date of incident (mm/dd/yyyy)	Time of incident (hh/mm a.m./p.m.)	
3	Specific location of accident. <i>(Ex. Second floor hallway of recreation center, storage closet of maintenance shed, south entrance of aquatic facility, etc.)</i>		
4	Are you reporting the injury for the first time using this form? Yes <input type="checkbox"/> No <input type="checkbox"/>		
	If no, when did you first report the injury (verbally or in writing) and to whom did you report it?		
5	Date: _____ Time: _____ Reported to: _____		
	Describe how the injury occurred. <i>(Identify the job task you were doing and include a step-by-step explanation of what led to the injury.)</i>		
6	Name all people present at the time of injury (e.g., coworkers and/or witnesses)		
7	Identify <i>all</i> body parts you injured. <i>(Be specific. Indicate left or right, upper or lower.)</i>		
8	Did you seek medical attention on the date of the accident? Yes <input type="checkbox"/> No <input type="checkbox"/>		
	If yes, where did you seek treatment?		

9	Have you injured this body part previously?	Yes	No
	If yes, please describe which body part and what the prior injury was.		
	If yes, where did you receive treatment?		
The above information is true and accurate:			
		(Employee signature)	Date
Notification of injury was received on:			
(Date received by employer representative)			
Notification of injury was received by:			
(Representative signature)			
(Printed name)			