



## PERTH NETBALL ASSOCIATION (INC) Injury Report

<p>To be completed by the injured person or witness. This form should be completed and forwarded to the Match Day Office on the same day the injury occurs. <b>Serious accidents and/or injury should be reported immediately to the First Aid Room attendant or Official in the Match Day Office.</b></p>									
<p><b>Did the injured party get injured whilst playing on a SGV or CFV? Yes / No</b></p>									
Name of Injured Party:									
Age:		Date of Birth:	/	/		Sex:			
Address:									
Home Phone:			Mobile:						
Signature:		<p><small>If under the age of 18 parent/guardian to sign.</small></p>							
Status of Injured Person:	Player	Official	Coach	Admin Staff	Spectator	Visitor	Umpire	Parent/Guardian	
Date of Injury:	/	/		Time:					
When Injury Occurred:	Game Day		Training		Carnival		PNA Trials		PNA Clinic
Where Injury Occurred:	Court #	Court Side #	Club Cages		Admin Building	Kiosk		Hall/Boardroom	
	Other:								
Is this Player subject to PNA Concussion Policy? Yes / No					Match Day Office Notified? Yes / No				
Describe how the injury occurred:									
<p>_____</p> <p>_____</p>									
Part of the body injured:									
Description of the injury:									
<p>_____</p> <p>_____</p>									
Is this a pre-existing injury/condition? Yes / No <small>(If yes please advise on the following 3 questions)</small>									
Are you receiving or have had any medical treatment for this pre-existing injury/condition? Yes / No									
Are you currently taking any medication for this injury? Yes / No									
Please advise the name & number of practitioner treating the injury:									
<b>Reportee / Witness Details</b>									
Reportee Name:				Witness Name:					
Position Held:				Position Held:					
Club/School:				Club/School:					
Phone:				Phone:					
<b>First Aid Administered at Site of Incident</b>									
Administered By:			Phone Mobile:			Phone Work:			

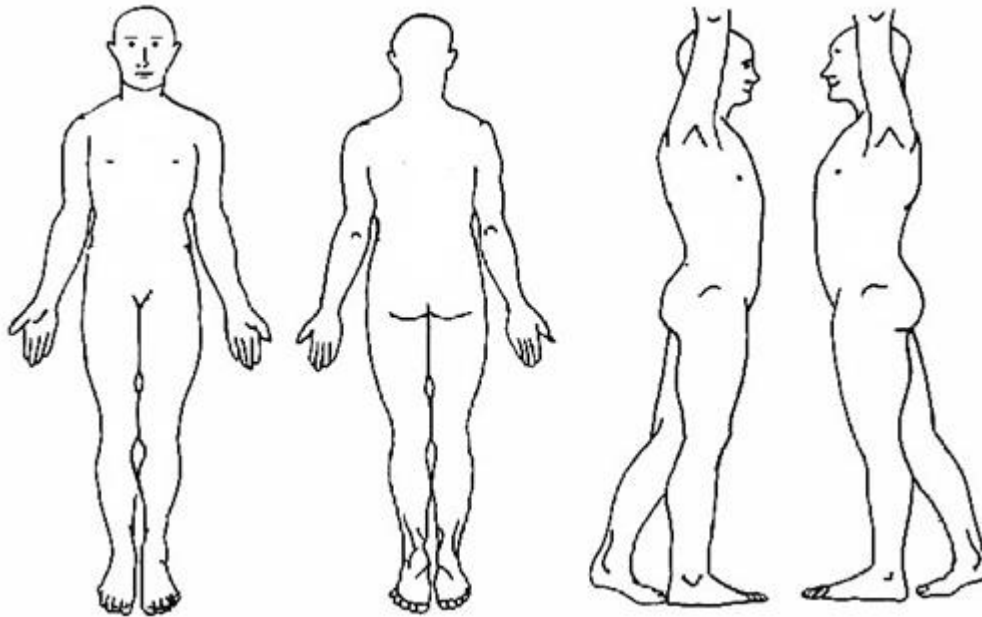
Please circle the description which best describes your status:

Player	Official	Coach	Admin Staff	Spectator	Umpire	Parent/ Guardian	Other:
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## **FIRST AID OFFICE USE ONLY**

To be completed by the First Aid / Physiotherapy Personnel

**BODY CHART**



Treatment:	RICER (Rest, Ice, Compression, Elevation)	Tape/Bandage	Wound Dressing	Other:
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Provisional Diagnosis:

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Recommendations:	Referral for X-Ray	Referral for DR / Hospital	Advice on Home Management & Return to Sport	Other:
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Was an ambulance required? Yes / No      Did the person lose consciousness at any time: Yes / No

Treatment Administered By: \_\_\_\_\_ Position: \_\_\_\_\_

Signature: \_\_\_\_\_ Date:    /    /  
 Time: \_\_\_\_\_

**Complete only if injured person refused treatment**

Did the injured person refuse treatment? Yes / No      Date:    /    /      Time: \_\_\_\_\_

Signature: \_\_\_\_\_  
If under the age of 18 parent/guardian to sign.      Signature of Trainer / Physiotherapist: \_\_\_\_\_

## **OFFICE USE ONLY**

Club Co-ordinator notified of concussion	Sent By: _____	Date:    /    /
Medical clearance received	Received By: _____	Date:    /    /