

# NM Rapids Soccer Club - Injury Report Form

## Reporting Procedure to NM Rapids SC:

Coaches will notify NM Rapids SC of any injury that should be evaluated by a medical professional (e.g. physician, nurse, athletic trainer). An injury report form will be completed by the coach and returned to the Club within 48 hours of the injury. Any injury requiring activation of the NM Rapids SC Emergency Action Plan should be reported to the Club no later than the end of that day by text/phone to Ray Nause at 505-417-0610.

Please send completed forms by email to: Ray Nause [ray.nause@nmrapids.org](mailto:ray.nause@nmrapids.org)

Injured Person	
<input type="checkbox"/> Player	<input type="checkbox"/> Coach
<input type="checkbox"/> Parent	<input type="checkbox"/> Spectator
<input type="checkbox"/> Other	_____
Name: _____	Date of Birth: ____/____/____
NMYSA/GA/ECNL/DPL/EA PLAYER ID# _____	
Team Name: _____	NMYSA Team #: _____

Parent/Guardian Information	
Names: _____	
Mailing Address: _____	
City: _____	State: _____ Zip Code: _____
Phone #: _____	email: _____

Injury Information	
Date: ____/____/____	Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM
Name of Venue: _____	
City: _____	State: _____
<b>Type of Activity at Which Injury Occurred:</b>	
<input type="checkbox"/> Training/Practice	<input type="checkbox"/> Scrimmage
<input type="checkbox"/> Game	<input type="checkbox"/> Other _____
<b>Sanctioning Organization for Activity at Which Injury Occurred:</b>	
<input type="checkbox"/> NMYSA	<input type="checkbox"/> ECNL
<input type="checkbox"/> EA	<input type="checkbox"/> GA
<input type="checkbox"/> DPL	<input type="checkbox"/> Other _____
<b>Field Surface at Which Injury Occurred:</b>	
<input type="checkbox"/> Grass	<input type="checkbox"/> Turf
<input type="checkbox"/> Indoor	<input type="checkbox"/> Other _____

Injury Details	
<b>Body Part Injured</b> <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> N/A <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Face <input type="checkbox"/> Eye <input type="checkbox"/> Nose <input type="checkbox"/> Mouth <input type="checkbox"/> Back <input type="checkbox"/> Chest <input type="checkbox"/> Internal <input type="checkbox"/> Shoulder <input type="checkbox"/> Arm <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Hand <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Leg <input type="checkbox"/> Ankle <input type="checkbox"/> Foot <input type="checkbox"/> Other _____	<b>Nature of Injury</b> <input type="checkbox"/> Concussion <input type="checkbox"/> Contusion <input type="checkbox"/> Laceration <input type="checkbox"/> Fracture <input type="checkbox"/> Dislocation <input type="checkbox"/> Sprain <input type="checkbox"/> Strain <input type="checkbox"/> Respiratory <input type="checkbox"/> Cardiac <input type="checkbox"/> Seizures <input type="checkbox"/> Cold Related <input type="checkbox"/> Heat Related <input type="checkbox"/> Other _____
<b>Please provide a detailed description of how the injury occurred, any player symptoms observed and any knowledge of injury type/severity:</b>  	
<i>Note: Any athlete with a suspected concussion must be removed from play and not return to activity until evaluated and cleared by a medical professional.</i>	

Injury Care	
<b>Immediate Care Provided By</b> <input type="checkbox"/> Athletic Trainer <input type="checkbox"/> Coach <input type="checkbox"/> Parent <input type="checkbox"/> EMS <input type="checkbox"/> Other _____	<b>Immediate Treatment</b> <input type="checkbox"/> Ice, Compression, Elevation <input type="checkbox"/> Rest <input type="checkbox"/> Wound care <input type="checkbox"/> Dressing for cuts/abrasions <input type="checkbox"/> Sling/Splint <input type="checkbox"/> CPR <input type="checkbox"/> AED <input type="checkbox"/> Spine stabilization <input type="checkbox"/> Other _____
<b>If treated at hospital/urgent care:</b> <input type="checkbox"/> Transported by ambulance <input type="checkbox"/> Transported by personal vehicle	

Person Completing Form	
Name: _____	Cell #: _____
Signature: _____	email: _____