SPECIAL OLYMPICS

**FORM I**





**FIRST REPORT OF ACCIDENT/INCIDENT**

# U.S. Program/Area:

South Dakota

**Date of Incident**:

**TYPE OF INJURY/ACCIDENT:**

 Bodily Injury

**Injured Person/Party Information** Date of Birth: / \_/\_\_ \_ Age:

Name: \_ \_

(Last) (First) (MI)

Address:

(Street) (City) (State) (Zip)

Home Phone: ( )\_ -\_ \_ Work Phone: ( ) \_ -\_ \_

Gender: Male Female Social Security Number: \_-

 Property Damage  Automobile

Other:



**INJURED PARTY:**

 Athlete  Spectator

 Volunteer  Unified Partner

 Coach  Property Owner  Employee

Other:



**Description of Accident** (If automobile accident occurred, please attach a copy of the police report). Describe how the accident occurred (attach a separate sheet if necessary):

**Site/event where accident occurred:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **ACCIDENT OCCURRED DURING:** | **DISPOSITION:** | INJURY: | | SPORT | SPORT cont. |
| Training/Practice | Released to parent | Head | | Alpine Skiing | Powerlifting |
| Competition | Refusal of care | Neck | | Aquatics | Relay Game |
| Traveling to or from SO event | Refer to doctor | Torso | | Athletics | Roller Skating |
| Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Refer to hospital or clinic | Back | | Badminton | Sailing |
|  | Medical attention | Hand | | Baseball | Snowboarding |
| **TYPE OF INJURY:** | EMS transport | Finger | | Basketball | Snowshoe |
| Severe cut w/bleeding | Patient requested EMS | Elbow | | Bocce | Soccer |
| Less serious bruise or cut | Released to personal vehicle | Shoulder | | Bowling | Softball |
| Break/fracture | Police | Leg | | Cheerleading | Speed Skating |
| Concussion | Ambulance | Knee | | Cross Country Ski | Swimming |
| Paralysis | Report only | Thigh | | Cycling | Table Tennis |
| Fatality | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Shin | | Equestrian | Team Handball |
| Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Toe | | Figure Skating | Tennis |
|  |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Floor Hockey | Track & Field |
|  |  |  | | Golf | Volleyball |
|  |  |  | | Gymnastics | Other: \_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  | | Kickball |  |
| **Contact/Care Provider Information** If an athlete or underage volunteer was injured, please identify care provider and/or responsible party (e.g. parent, legal guardian). | | | | | |
| Relationship to the injured person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Employer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Employer Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Work Phone: (\_\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Home Phone: (\_\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |  | | |
| Does the injured person have medical Insurance?  Yes  No | | |  | | |
| If yes, insurance is provided by:  Injured Person  Care Provider/Responsible Party | | | | | |
| Please provide name of Company and Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
|  | | |  | | |
| **Witness Information** (Please provide names and phone numbers of any witnesses to the incident) | | | | | |
| Witness #1 Name: | | | Daytime Phone: (\_\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Witness #2 Name: | | | Daytime Phone: (\_\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
|  | | |  | | |
| **Special Olympics Official / Representative** (other than claimant) | | |  | | |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Daytime Phone: (\_\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |  | | |
|  | | |  | | |
| **SUBMIT ACCIDENT MEDICAL CLAIMS TO:** | | | **SUBMIT LIABILITY CLAIMS TO:** | | |
| HEALTH SPECIAL RISK, INC. (HSR) | | | AMERICAN SPECIALTY INSURANCE | | |
| HSR Plaza II, 4100 Medical Parkway, Carrollton, TX 75007 | | | 7609 W. Jefferson Blvd., Suite 150, Fort Wayne, IN 46804 | | |
| Toll Free: 800.328.1114 Fax: 972.512.5820 | | | Toll Free: 800.566.7941 Fax: 260.969.4729 | | |
| Email: claims@hsri.com | | | Email: [claims@americanspecialty.com](mailto:claims@americanspecialty.com) | | |
|  | | |  | | |
|  | | | IF INJURY WAS SERIOIUS OR FATAL, IMMEDIATELY NOTIFY | | |
|  | | | AMERICAN SPECIALTY at 800.566.7941 | | |
|  | | | We provide 24/7 Emergency Claims Phone Coverage | | |