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 |
|  |  |
|  | IF INJURY WAS SERIOIUS OR FATAL, IMMEDIATELY NOTIFY |
|  | AMERICAN SPECIALTY at 800.566.7941 |
|  | We provide 24/7 Emergency Claims Phone Coverage |