UNIVERSITY OF DELAWARE
COOPERATIVE EXTENSION

DELAWARE 4-H ACCIDENT/INCIDENT REPORT FORM

The Delaware Cooperative Extension is requesting information to report the nature and circumstances of accidents and incidents occurring at UDCE programs. If you do not provide requested information the report may be without pertinent information. The information you provide may be shared with UDCE employees, UDCE volunteers, officials, medical personnel, and others as appropriate.. Information provided to UDCE may also be shared among offices within the University of Delaware and outside entities as necessary or appropriate in the conduct of legitimate University business and consistent with applicable law.

Camp / Event Name: _____ Date: _____

Date of Incident/Accident: _____ Hour: _____ a.m. / p.m.

Type of incident: Behavioral – Accident – Epidemic - Illness - Other (describe): _____

Address / Location of Event: _____

Name of injured person(s) involved: _____Date of Birth: _____ Gender: _____

Circle one: Participant Camper Visitor UDCE Volunteer UD Employee Parent

Address: _____ Phone: _____

Name of Parent/Guardian (if minor): _____

Address: _____ Phone: _____

Name/Addresses/**Telephone Number** of Witnesses (Attach signed statements):

1. _____

2. _____

3. _____

Describe the Accident/Incident in detail, including the sequence of activities and what the individual/injured was doing. [Attach extra pages if needed]:

_____

_____

_____

Where occurred? [Specify location of accident/incident, including location of individual/injured and witness(es). Use diagram to locate persons/objects, if appropriate]:

Was individual/injured participating in an activity at time of injury? _____ Yes _____ No

If so, what activity? _____

_____

Actions taken at time of incident/accident: by Extension Employee(s) or UDCE volunteer(s) _____

_____

Actions taken to prevent similar incident/accident _____

_____

Medical Report of Accident / Incident

Were parents notified? Yes____ No ____ By: Writing _____ Phone_____ Other _____

By whom? _____Title: _____ When? [time & date]: _____

Parent's Response: _____

Description of Injuries: _____

If first aid/treatment was given at the camp/event site, describe:

Where: _____; By whom: _____

Action(s) taken:_____

Additional Assistance Summoned? Yes___ or No___. If yes, time of call:_____

Ambulance #/Name of Company Responding: _____

Police Department/Officer Responding:_____

Was injured transported? Yes___ or No___. If yes: By Whom: _____

Where: Doctor's Office____, Hospital ____, Camp/Site Health Service____, Other _____

Person(s) to be notified of transport (attempt to notify immediately and continue efforts):

Name(s) _____ Phone #:_____ Relationship to injured: _____

Contact Made: Date_____; Time _____; Method _____

If not transported, subsequent action taken: _____

Check here if Injured (over 18 or parent or guardian if under 18) refused treatment _____ or transport _____

UDCE Persons notified of accident / incident:

Name: _____ Position: _____ Date: _____

Name: _____ Position: _____ Date: _____

Name: _____ Position: _____ Date: _____

Describe any contact made with/by the media regarding this situation: _____

Signed: _____ Position: _____ Date: _____

Insurance Notification:

1. Parent's Insurance Date: _____ By: ___ Parent ___UDCE
2. UD Health Insurance Date: _____ By: ___ Parent ___UDCE
3. Worker's Compensation Date: _____ By: ___ Parent ___UDCE
4. Camp/Event Accident Insurance Date: _____ By: ___ Parent ___UDCE