



ACCIDENT/INCIDENT REPORT FORM

- This form is to be used for all accidents or incidents, whether an injury occurred or not, and for all important incidents involving disruptive or dangerous situations.
- File this report within 24 hours of an accident/incident during a Girl Scout activity.
- Note: There is a separate Form #2242 for Accident/Incident at GS Summer Camp.
- Please type or print clearly in black or blue ink.

Fax or mail completed form to:
Girl Scouts of Connecticut
Attn: Accident/Incident Reports
Hartford Service Center
340 Washington Street
Hartford, CT 06106
Phone (860) 522-0163 Fax (866) 735-3447

A. Description of Accident/Incident

<input type="checkbox"/> Accident (please check all that apply below) <i>(Any happening resulting in injury to a person or property)</i>				<input type="checkbox"/> Incident <i>(Any mishap, conflict, inappropriate behavior, or situation that could cause injury or could present a liability to the Council)</i>			
<input type="checkbox"/> Injury to a person (complete both A & B)				<input type="checkbox"/> Injury to property			
Person Involved/Injured							
Full Name of Person/s Involved		Troop #	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Please check all that apply: <input type="checkbox"/> Staff <input type="checkbox"/> GS Member <input type="checkbox"/> Non-member <input type="checkbox"/> Volunteer <input type="checkbox"/> Other (explain)		
Address			City	ST	Zip		
Parent or Guardian <i>(if minor)</i>				Email			
Home Phone () ()		Cell Phone () ()		Work Phone () ()			
Nature of Accident/Incident <input type="checkbox"/> Behavioral <input type="checkbox"/> Animals/plants/insects <input type="checkbox"/> Slips/Falls <input type="checkbox"/> Use of Tools <input type="checkbox"/> Illness <input type="checkbox"/> Acts of Nature <input type="checkbox"/> Other (please describe)							
Description of Accident/Incident <i>(Please attach additional explanation, if needed.)</i>							
Day of Week	Month/Day/Year / /	Hour	<input type="checkbox"/> AM <input type="checkbox"/> PM	Location			
Was (injured) person participating in an activity at time of injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, what activity? (check below)							
<input type="checkbox"/> Troop Trip <input type="checkbox"/> Troop Camping <input type="checkbox"/> Council Event <input type="checkbox"/> Service Unit Event <input type="checkbox"/> Training <input type="checkbox"/> Other (please describe)							
Describe the sequence of activities in detail, including what the (injured) person was doing at the time, if applicable.							
Where occurred? (Specify location, including location of injured/involved and witnesses. Make diagram on a separate paper, if necessary to locate persons/objects.)							
Any equipment involved in accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, what kind?							
What could the injured/involved person have done to prevent injury or incident?							
Emergency procedures followed at time of accident/incident, including First Aid/CPR/Medical Treatment, emergency transportation, etc., provided (describe).							
By whom? (Please include full name, phone number, and title/qualifications.)							
Who was notified? <input type="checkbox"/> Parents <input type="checkbox"/> 911 <input type="checkbox"/> Ambulance <input type="checkbox"/> Police <input type="checkbox"/> Camp Nurse <input type="checkbox"/> Troop First Aider/CPR <input type="checkbox"/> Council (name contact)				How? <input type="checkbox"/> Writing <input type="checkbox"/> Phone <input type="checkbox"/> In person <input type="checkbox"/> Other (explain on back)		Time, day notified?	
Name of Person Completing This Form		Position	Phone () ()	Date / /			
Address			City	ST	Zip		
Names and contact information of witnesses <i>(You may wish to attach signed statements.)</i>							
Name	Address			Phone () ()			
Name	Address			Phone () ()			
Name	Address			Phone () ()			



ACCIDENT/INCIDENT REPORT FORM (CONT.)

- If injury occurred to a person, both A and B sections must be completed.
- For an accident claim to be processed for non-staff Girl Scout adults and girls, include a completed Mutual of Omaha Form #M18979 available from the Membership Department at your local Service Center, or http://www.mutualofomaha.com/girl_scouts_of_the_usa/forms.html.
- Please type or print clearly in black or blue ink.

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B. Medical Report of Accident

If a minor was injured, have parents/guardians been notified?			
By whom?	Title	Time <input type="checkbox"/> AM <input type="checkbox"/> PM	Date / /
Parent's/Guardian's response			
Treatment (Complete. Check all that apply.)			
Where was treatment given?			
<input type="checkbox"/> At accident site	By whom?	Title/Position	
List treatment given			Date / /
<input type="checkbox"/> Doctor's Office <input type="checkbox"/> Dentist's Office	Name of Physician/Dentist	Location	
List treatment given			Date / /
Released to: <input type="checkbox"/> Return to activities <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Other			
<input type="checkbox"/> Hospital	Hospital Name	Location	
Was injured retained overnight in hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Out-patient <input type="checkbox"/> In-patient	Date / /
Date released / /	Released to: <input type="checkbox"/> Return to activities <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Other		
Comments			
Council staff notified			
Name	Position	Date / /	
Describe any contact made with/by media regarding this situation. <input type="checkbox"/> Newspaper <input type="checkbox"/> TV <input type="checkbox"/> Radio <input type="checkbox"/> None (Do not make any statements to the press; refer all media contact to the CEO, Hartford Service Center.)			

Signature _____ Date _____

FOR OFFICE USE ONLY

Date Form Received _____ Original to CFO Copies to: Human Resources CEO COO Sr. Director of Membership Svcs.

Follow-up phone call needed? Yes No

Comments

Workers Comp. Claim filed? Yes No Date filed ____/____/____ Claim # _____

Girl Scout Insurance Filed? Yes No Date filed ____/____/____

Attachments Medical Receipts Other

Follow-up needed? Yes No

Comments