

**MIT Recreational Sports
Illness / Injury / Accident Report Form**

Personal Information of Injured Person

Name: _____ Email: _____ ID#: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Gender: Male Female Age: _____ DOB: ____/____/____

Affiliation: Student Faculty/Staff Community / Friend of MIT
 Alumni Membership: Member Non-Member

Date of Injury: ____/____/____ Time of Injury ____:____ AM / PM

Facility

Please indicate where in the DAPER facilities the injury occurred:

- | | | | |
|--|--|---|--|
| Alumni / Wang | Johnson | duPont | Zesiger Center |
| <input type="checkbox"/> Alumni Pool | <input type="checkbox"/> Athletic Training | <input type="checkbox"/> Basketball / Gym | <input type="checkbox"/> 2nd Floor Fitness |
| <input type="checkbox"/> M Locker Room | <input type="checkbox"/> Equipment Room | <input type="checkbox"/> Gymnastics | <input type="checkbox"/> 3rd Floor Fitness |
| <input type="checkbox"/> Spin Studio | <input type="checkbox"/> Lobby | <input type="checkbox"/> Indoor Golf | <input type="checkbox"/> DAPER Offices |
| <input type="checkbox"/> Group Ex Studio | <input type="checkbox"/> Rink | <input type="checkbox"/> M Locker Room | <input type="checkbox"/> M Locker Room |
| <input type="checkbox"/> W Locker Room | <input type="checkbox"/> Restrooms | <input type="checkbox"/> Squash | <input type="checkbox"/> MAC |
| <input type="checkbox"/> Wang Fitness | <input type="checkbox"/> Track | <input type="checkbox"/> T-Club | <input type="checkbox"/> Pool |
| <input type="checkbox"/> Rockwell Cage | <input checked="" type="checkbox"/> FIELD / OTHER: _____ | <input type="checkbox"/> W Locker Room | <input type="checkbox"/> W Locker Room |

Injury

Nature of Injury:

- | | | |
|--------------|----------------|------------|
| Abrasion | Bruise | Laceration |
| Amputation | Bump | Poisoning |
| Asphyxiation | Cut | Puncture |
| Bite | Electric Shock | Scald |
| Bone Injury | Joint Injury | |
| Other: | | |

Additional space is located on back to detail specifics of injury.

Part of Body Injured: ** Right or Left part of Body **

- | | | |
|--------|----------|-----------|
| Scalp | Shoulder | Hip |
| Head | Back | Thigh |
| Face | Arm | Knee |
| Eye | Hand | Lower Leg |
| Mouth | Fingers | Ankle |
| Neck | Abdomen | Foot |
| Other: | | |

How injury occurred: _____

Actions Taken

Brief Description of Treatment/First Aid/Care Given: _____

Treatment Refused? Yes No
 911 or 100 Called? Yes No Referred to physician or Health Center? Yes No
 Only Assessed by EMT's? Yes No
 Treated/Transported by Ambulance? Yes No EMS Response: MIT Pro EMS Cambridge Rescue
 If Minor, was parent/other notified? Yes No

Case #/Officer Name: _____ Hospital sent to: _____

If 911 was not called, please comment on why/other comments : _____

Witness (other than preparer of report)

Name: _____ Phone #: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Notes: _____

Signature (injured person)

I have read the above account of the incident involving my illness or injury. I find it true and complete.

Signature: _____

Date: _____

I hereby refuse any and all First Aid assistance offered by the employees of HealthFitness and MIT, I also understand that I may choose to not seek medical treatment as recommended by HealthFitness.

Signature: _____

Date: _____