



ILLINOIS YOUTH SOCCER ASSOCIATION MEDICAL REPORT

Event _____ Event Date(s) _____

Name _____ Birthdate _____

Street Address _____

City, State, Zip _____

Home Phone (_____) _____ Date of Incident _____ Time: _____ AM/PM

Witness: _____ Title: _____ Phone (_____) _____

Witness: _____ Title: _____ Phone (_____) _____

ACTIVITY: _____

DESCRIPTION: _____

ASSESSMENT: _____

IMMEDIATE ACTION: _____

DISPOSITION OF PLAYER: _____

DID PLAYER RETURN TO ACTIVITY? YES NO IF YES, INDICATE TIME: _____ AM/PM.

IF YES, INDICATE CAPACITY: FULL LIMITED AS TOLERATED: _____

CONTACT _____ TIME CONTACT WAS NOTIFIED _____ AM/PM

CONTACT TYPE: PERSONAL CONVERSATION PHONE WRITING

WHERE PLAYER'S PARENTS/GUARDIAN CONTACTED? YES NO IF YES, INDICATE TIME: _____ AM/PM.

CONVERSATION NOTES: _____

WAS PLAYER REFERRED? YES NO IF YES, WHERE: _____

RESULTS: _____

Player's Signature

Date

Attending Paramedic/Medical Trainer's Signature

Date