



<b>Details of Accident/Incident</b>	
Date occurred:	Time occurred:
What happened?	
Location:	
Workshop Space <input type="checkbox"/> Rehearsal Space <input type="checkbox"/> Performance Venue <input type="checkbox"/> Public space <input type="checkbox"/> Other	

<b>Were there any witnesses?</b>	
Name: _____	Tel: _____
Name: _____	Tel: _____
<b>To whom was the incident/accident reported?</b>	
Parent/Guardian <input type="checkbox"/> Local GP <input type="checkbox"/> Designated Welfare Person <input type="checkbox"/> Other _____ <input type="checkbox"/>	
Name: _____ Surname _____	
Address: _____	
Home tel: _____ Mobile : _____	
Name: _____ Surname _____	
Address: _____	
Home tel: _____ Mobile : _____	

**To whom did the accident occur? Incident affect?**  
 Youth Theatre Member  Facilitator  Welfare Person  Volunteer  Other \_\_\_\_\_

Name: \_\_\_\_\_ Surname: \_\_\_\_\_  
 Home Address \_\_\_\_\_  
 Home Tel: \_\_\_\_\_ Mobile: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Male  Female

Did they agree to the suggested course of action? Yes  No

Did the incident/accident cause illness/injury? Yes  No

<b>Apparent Nature of Injury</b>	<b>Part of Body Injured</b>
<input type="checkbox"/> Abrasion <input type="checkbox"/> Concussion <input type="checkbox"/> Puncture	<input type="checkbox"/> Abdomen <input type="checkbox"/> Eye L/R <input type="checkbox"/> Hand L/R
<input type="checkbox"/> Amputation <input type="checkbox"/> Cut <input type="checkbox"/> Scald	<input type="checkbox"/> Ankle L/R <input type="checkbox"/> Elbow L/R <input type="checkbox"/> Knee L/R
<input type="checkbox"/> Asphyxiation <input type="checkbox"/> Dislocation <input type="checkbox"/> Scratch	<input type="checkbox"/> Arm L/R <input type="checkbox"/> Face <input type="checkbox"/> Leg L/R
<input type="checkbox"/> Bite <input type="checkbox"/> Fracture <input type="checkbox"/> Shock	<input type="checkbox"/> Back <input type="checkbox"/> Foot L/R <input type="checkbox"/> Mouth
<input type="checkbox"/> Bruise <input type="checkbox"/> Laceration <input type="checkbox"/> Sprain	<input type="checkbox"/> Chest <input type="checkbox"/> Finger <input type="checkbox"/> Neck
<input type="checkbox"/> Burn <input type="checkbox"/> Poisoning <input type="checkbox"/> Other	<input type="checkbox"/> Ear L/R <input type="checkbox"/> Head <input type="checkbox"/> Other

Explain Other: \_\_\_\_\_ Explain Other: \_\_\_\_\_

Describe the nature of the injury (cut, third finger, left hand. etc.)  
 \_\_\_\_\_

**Treatment Details**

None  First Aid  Local GP/Clinic  Advised to see own GP on return   
 Accident and Emergency Department  Hospital Stay

In the case of First Aid:  
 Who administered First Aid: \_\_\_\_\_ Contact Number \_\_\_\_\_  
 What First Aid was administered: \_\_\_\_\_  
 \_\_\_\_\_

In the case of a Hospital Stay:                      Length of Stay: \_\_\_\_ days  
 Date of Admittance: \_\_\_\_\_ Time of Admittance: \_\_\_\_\_  
 Date of Discharge: \_\_\_\_\_ Time of Discharge: \_\_\_\_\_

Did the accident/incident occur during a workshop/planned artistic activity? Yes  No   
 Explain  
 \_\_\_\_\_  
 \_\_\_\_\_

Did the accident involve any props, sets or technical equipment?    Yes     No   
Specify and explain

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Did the accident/incident occur during plan social activities?    Yes     No   
Specify and explain

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Did the accident/incident occur unplanned activities?    Yes     No   
Specify and explain

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Was a leader or responsible adult present at accident?    Yes     No   
If no, explain

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**Details of Person completing this Form**  
Name: \_\_\_\_\_ Role or relation to injured/ill party: \_\_\_\_\_  
Tel: \_\_\_\_\_ Email: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
Signature: \_\_\_\_\_ Today's Date: \_\_\_\_\_