



Paddle Newfoundland Labrador INCIDENT REPORT

Date and Time of Incident: Date: _____ Time: _____ AM/PM

Patient Information:

Last Name		First Name	
Street Address		City	Postal Code
Phone	Email		
Age	DOB	Gender	
Known Medical Conditions/Allergies:			

Charge Person Information:

Last Name		First Name	
Street Address		City	Postal Code
Phone	Email		
Role(Leader, Sweep, Activity Participant, Bystander)			

Incident Information:

Date and Time of First Intervention: Date: _____ Time: _____ AM/PM	Date and Time of Medical Support Arrival: Date: _____ Time: _____ AM/PM
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After Treatment, The Patient Was:

Sent Home: <input type="checkbox"/>	Sent to Hospital: <input type="checkbox"/>	Resumed Activity: <input type="checkbox"/>
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Charge Person Description of Incident:

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Patient Description of Incident:

Event Conditions:

Actions Taken/Intervention:

Other Information:

Form Completed By: _____
Print Name

Signature

Date: _____