

# Accident/Incident Report Form

The leader/advisor, staff member or trained adult responsible for an event or activity, must complete one form for each person involved in an incident or injured and submit to [mvp@gsmists.org](mailto:mvp@gsmists.org) or a Girl Scouts of Michigan Shore to Shore Service Center within 48 hours of the accident or incident.

Date of accident/incident: \_\_\_\_\_ Time: \_\_\_\_\_

Name of person: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Girl       Volunteer       Staff       Other \_\_\_\_\_

Parent/guardian name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

**Name of person completing this form:** \_\_\_\_\_ **Position:** \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**Type of Incident:**

Injury Accident       Abuse Disclosure       Behavior       Policy/Procedure Violation       Other \_\_\_\_\_

Event Name: \_\_\_\_\_

Address of incident location: \_\_\_\_\_

Describe the incident in detail. Use diagrams if needed: (Use additional paper if necessary)  
\_\_\_\_\_

List the name/address/phone of any witnesses: (Use additional paper if necessary)  
\_\_\_\_\_

Describe actions taken and identify who else was involved. Please include Name/Address/Ph.  
(Use additional paper if necessary)  
\_\_\_\_\_

**Report of Accident Requiring Medical Treatment**

Where was treatment given? (Check all that apply)  Accident site  Hospital  Doctor's Office  Medical Center

If treatment was done at accident site, list that location: \_\_\_\_\_

Name of Professional treatment provider: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_

Describe the nature of the injury. Be as detailed as possible. Ex: right leg cut, left hand bruised etc.:  
(Use additional paper if necessary)

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Describe treatment given: (Use additional paper if necessary)

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Was parent/guardian notified?  Yes  No  N/A By:  Phone  Other \_\_\_\_\_

By Whom? \_\_\_\_\_ Title: \_\_\_\_\_ Date/Time: \_\_\_\_\_

Parent/guardian response:

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Was the injured person retained overnight in camp health service?  Yes  No

Date released from camp health service: \_\_\_\_\_ Released to:  Camp Activities  Home  Other \_\_\_\_\_

Was the injured person retained overnight in a hospital?  Yes  No

Date released from hospital: \_\_\_\_\_ Released to:  Parent  Camp  Other \_\_\_\_\_

Comments/directions: \_\_\_\_\_

Persons notified: (Council staff, Camp Director, etc.)

Name	Position	Date	Time
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Describe any contact with/by the media regarding this situation:

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Signed: \_\_\_\_\_ Position: \_\_\_\_\_ Date: \_\_\_\_\_