AYSO INCIDENT REPORT FORM

Complete this form for any of the following: *(check type)*

☒ Injury/illness ☐ Threats ☐ Fights ☐ Property damage ☐ Calls to Police ☐ Other

*Return **completed** form to the Regional Commissioner, Safety Director, Area Director, or Tournament Director.*

AFFECTED PARTY: ☒ Player ☐ Official ☐ Coach ☐ Spectator ☐ Volunteer ☐ Other | **AYSO ID #** 58032636 | **Region #** 149

Last Name	First Name	MI	Birth date:
Schlegelmann	Kai	Y.	12/29/02

Phone: (541) 745-5178

Address: 5993 NW Rosewood Dr. | City: Corvallis | State: OR | Zip: 97330

Does the injured person have other medical insurance? Yes ☒ No ☐ *If yes, please provide name of company and policy #:* Samaritan Choice Wellness

Employer Name & Address: Samaritan Health Plan Operations

GUARDIAN/PARENT ***(if affected party is a minor)*:**

Last Name: Schlegelmann | First Name: Bonnie | MI: L. | Telephone Number: (541) 745-5178

Address: 5993 NW Rosewood Dr. | City: Corvallis | State: OR | Zip: 97330

INCIDENT INFO:	*Date of Incident:*	*Age Division:*	☒ Boys ☐ Girls	*Time of Incident:* AM / PM
	9/20/14	U12B		12 (noon)

Tournament Name & Location *(if applicable)*

Team Involved #1: Falcons | Coach Name: Tiffany Smith | Region #

Team Involved #2: | Coach Name: | Region #

FOR INJURIES: BODY PART INJURED			TYPE OF INJURY			FIELD SURFACE	LOCATION
☐ Ankle (L/R)	☐ Shoulder(L/R)	☐ Tooth	☐ Abrasion	☐ Dislocation	☐ Pain	☐ Dirt	☐ Before Competition/Event
☐ Knee (L/R)	☒ Wrist (L/R)	☐ Back	☐ Burn	☐ Foreign Body	☐ Seizures	☒ Grass	☒ During Competition/Event
☐ Leg	☐ Finger	☐ Neck	☐ Cardiac	☒ Fracture	☐ Sting/Bite	☐ Turf	☐ After Competition/Event
☐ Foot	☐ Eye (L/R)	☐ Internal	☐ Cold Injury	☐ Heat Exhaustion	☐ Strain	☐ Indoor	☐ Concession Area
☐ Toe	☐ Ear (L/R)	☐ No injury	☐ Concussion	☐ Laceration	☐ Sprain		☐ Parking Lot
☐ Arm	☐ Nose	☐ Other	☐ Contusion	☐ Nausea			☐ Restrooms
☐ Hand	☐ Head						

CAUSE	OUTCOME		POLICE REPORT FILED?:
☒ Collision (participant/spectator)	*No care given:*	*Referral*	☐ Yes ☒ No *Report No:*
☐ Struck by falling/flying object	☐ Not Needed	☒ To Doctor	*Officer's Name & Contact No:*
☐ Struck by or fell into goal	☐ Patient Refused	☒ To Hospital/Clinic	
☐ Animal/insect bite/sting			
☒ Slip/Fall	*Released:*	*EMS transport:*	
☐ Assault/Sexual	☐ To Parent	☐ Region Recommended	
☐ Assault/Non-Sexual	☐ To Personal Vehicle	☐ Patient/Parent Requested	
☐ Property Damage			

Describe how the incident, injury or property damage occurred: ***(use the backside or attach a separate sheet if necessary – may attach a copy of the Referee Game Misconduct Report)***

collided with opposite team player & fell back onto his wrist/hand (left) fracturing the radius. splinted then casted.

WITNESS INFORMATION - Confidential

Name	Address	Phone Number
Nobody realized he was injured until after. He didn't say anything until the end of the quarter. His parents dealt with it immediately.		

Person/volunteer completing/submitting this form:

Name: Tiffany Smith	*Signature:* Tiffany Smith	Ph: ( ) Cell: (541) 990-2091
Position Title: Coach	*e-mail address:* tiffanysmith0102@gmail.com	Date: 9/27/14
Regional Commissioner: *print name* Leanne Henrique	*Signature:* LH. (Big Elk R149 Safety Dir.)	Date: 4/25/2015

AYSO Staff: Forward copy of completed form to AYSO, Attn: Risk Mgmt, 19750 S Vermont Ave, Suite 200, Torrance, CA 90502 or scan and email to riskmanagement@ayso.org.

Rev 11-13-2013-hv

SCHLEGELMANN, KAI (id #3324, dob: 12/29/2002)

09/24/2014

From Provider	To Provider
PETER C. TSAI, MD UPPER HAND ORTHOPAEDICS PC 2797 NW 9TH ST CORVALLIS, OR 97330-3857 Phone: (541) 207-0910 Fax: (541) 738-2596	

Order Information

Order
Orders included: 1 **Closed Colles' fracture** **ICD-9: 813.41: Closed colles' fracture** • **INSTRUCTIONS TO SCHOOL** **Note to Provider: Kai may participate in soccer drills, no scrimmage or games. He is allowed to participate in PE however there is to be no lifting or contact with the left arm.**

Patient Information

Patient Name	**SCHLEGELMANN, KAI**
DOB	**12/29/2002**
Primary Insurance	**SAMARITAN CHOICE PLAN (PPO)** **ID: 10004880604** **Policy Holder: SCHLEGELMANN, KAI**
Secondary Insurance	**None recorded.**

Electronically Signed by: PETER C. TSAI, MD