

Incident/Injury Report Form

Please Print

In the event of injury while volunteering,
please notify City of Oakland staff immediately at
adoptaspot@oaklandnet.com, 510-238-7630.

Name of (Injured Person)	Gender M <input type="checkbox"/> F <input type="checkbox"/>	Birthday	E-Mail
Address of Injured Person and Best Contact Phone Number (Include Area Code)			
If Applicable, Parent's Name, Address, and Best Contact Phone Number (Include Area Code)			
Date and Time of Accident	Place where Accident Occurred		
Type of Injury suspected if known (Check any that apply): <input type="checkbox"/> Bruise <input type="checkbox"/> Dislocation <input type="checkbox"/> Laceration <input type="checkbox"/> Concussion <input type="checkbox"/> Fracture <input type="checkbox"/> Sprain/Strain			
Other(Specify) _____ _____			
Body Part Injured (Note side of Injury using "R" for Right side and "L" for Left Side) <input type="checkbox"/> Hand <input type="checkbox"/> Foot <input type="checkbox"/> Arm <input type="checkbox"/> Shoulder <input type="checkbox"/> Back <input type="checkbox"/> Head <input type="checkbox"/> Face <input type="checkbox"/> Foot <input type="checkbox"/> Leg <input type="checkbox"/> Chest <input type="checkbox"/> Eye			
Other(Specify) _____ _____			
Was First Aid rendered? Describe if yes: _____ _____			
Was an Ambulance recommended? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, did the injured refuse? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Were teeth injured? If so, which ones?	Describe Condition of Injured Teeth Prior to Accident: <input type="checkbox"/> Whole, Sound, and Natural <input type="checkbox"/> Filled <input type="checkbox"/> Capped <input type="checkbox"/> Artificial		
Did Injury Result in Death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Describe How Accident Occurred – Give All Possible Details 			
Form completed by			
Print Name _____		Signature _____	
		Date _____	