USA WRESTLING MEDICAL SERVICES

INJURY REPORT

NAME_____TEAM_____WEIGHT CLASS_____EVENT_____

TOURNAMENT_____COACH/PARENT_____

COMTACT INFO:_____PRESENT Y N DOB_____

INJURY ONSET:_____DATE OF EVAL:_____TIME:_____

INJURY ALERT: YELLOW RED

BODY PART:_____R L ACUTE/CHRONIC CONCUSSION Y N N/A LOC

SCAT 6 COMPLETED Y N

MECHANISM O INJURY:

PREVIOUS INJURY: YES EXPLAIN:

CHIEF C/O:

EVAL FINDINGS:

ASSESSMENT:

ACTION:

ASSESSMENT DATE:_____TIME EMS CALL:_____EMS ARRIVAL:_____

TRANSFER OF CARE:_____ATHLETE STATUS RELEASE:_____

DID ATHLETE RETURN TO COMPETITION: Y N

REFERRAL STATUS: RECOMMENDED Y N REQUIRED: Y N

REFERRAL TO WHOM

STAFF:_____SIGN:_____DATE:_____

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