

USA BOXING INJURY REPORT

Use this form for ANY injury to spectator as well as athlete and non-athletes
(Check and/or circle one per section, complete relevant blanks)



Injured: (Member) (Spectator) (Other: _____)
 Name: _____ Age: _____ Sex: (M) (F)
 Parents Name (If minor): _____
 Address: _____
 City: _____ State: _____ Zip: _____ Phone: () _____
 Sanction #: _____ Member's Reg. #: _____
 Member's Reg. Date: _____ SSN: _____
 Name of Location Where Injury Occurred: _____
 Name of Local Boxing Committee: _____

INJURY:	TIME:	DISPOSITION:
Date of Injury: _____	<input type="checkbox"/> Morning	<input type="checkbox"/> Ringside Physician Attention
Injured Body Part: _____	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Auto to Hospital
Condition: _____ (Sprain, Fracture, Concussion, etc.)	<input type="checkbox"/> Evening	<input type="checkbox"/> Ambulance to Hospital
Estimated absence from boxing (1-7 days) (1-3 weeks) (3+ weeks)		

OCCASION:	ACTIVITY:	SITUATION:
<input type="checkbox"/> During supervised practice Name of supervising coach _____ <input type="checkbox"/> In sanctioned competition Round _____ <input type="checkbox"/> Other: Weight Class: _____	<input type="checkbox"/> Sparring <input type="checkbox"/> Bag / Pad work <input type="checkbox"/> Rope Jumping <input type="checkbox"/> Weights <input type="checkbox"/> Calisthenics <input type="checkbox"/> Road work <input type="checkbox"/> Other:	<input type="checkbox"/> Hit by opponent <input type="checkbox"/> Hit opponent <input type="checkbox"/> Fell (pushed) (slipped) (tripped) (lost balance) <input type="checkbox"/> Other: (Describe fully below)
PROGRAM: <input type="checkbox"/> USA Boxing <input type="checkbox"/> Golden Gloves <input type="checkbox"/> Silver Gloves <input type="checkbox"/> PAL <input type="checkbox"/> NCBA <input type="checkbox"/> Intl Club Exchange <input type="checkbox"/> Other:	LOCATION: <input type="checkbox"/> Locker room <input type="checkbox"/> Ring <input type="checkbox"/> Gym floor <input type="checkbox"/> Spectator area <input type="checkbox"/> Other:	PROTECTIVE EQUIPMENT: Wearing mouthpiece? (yes) (no) Wearing headgear? (yes) (no)

DESCRIBE HOW INJURY HAPPENED:

Signature of Local Boxing Committee Officer validating injury claim: _____ Date: _____

Print Name: _____ Phone: () _____