

# Otsego Rocket Football (ORF)

## Player Injury Form

**Practice or Game (Circle One)**

**Player Name:** \_\_\_\_\_

**Coaches Name:** \_\_\_\_\_

**Player Group: (Check One)**

- 8 and 9 Years
- 10 and 11 Years

**Date of Injury:** \_\_\_\_\_

*Circle All That Apply*

<b>Accident Location</b> <input type="checkbox"/> Competition Area <input type="checkbox"/> Practice Area <input type="checkbox"/> General Area <input type="checkbox"/> Off Property	<b>Injury</b> <input type="checkbox"/> Contact w/Player <input type="checkbox"/> Slip/Fall <input type="checkbox"/> Overexertion <input type="checkbox"/> Object	<b>Medical Services</b> <input type="checkbox"/> Parent Care <input type="checkbox"/> Local Care (Trainer) <input type="checkbox"/> Emergency Services <input type="checkbox"/> None
<b>Primary Injury</b> <input type="checkbox"/> Contusion <input type="checkbox"/> Laceration <input type="checkbox"/> Fracture <input type="checkbox"/> Heat Exhaustion <input type="checkbox"/> Sting <input type="checkbox"/> Sprain <input type="checkbox"/> Other:	<b>Body Part Injured</b> <input type="checkbox"/> Head/Neck <input type="checkbox"/> Arm <input type="checkbox"/> Leg <input type="checkbox"/> Hand/Foot <input type="checkbox"/> Hip <input type="checkbox"/> Back <input type="checkbox"/> Knee <input type="checkbox"/> Ankle	<b>Body Part Injured</b> <input type="checkbox"/> Eye <input type="checkbox"/> Nose <input type="checkbox"/> Tooth <input type="checkbox"/> Ear <input type="checkbox"/> Internal <input type="checkbox"/> Face <input type="checkbox"/> Wrist

**Notes:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Signatures:**

**Parent/Guardian:** \_\_\_\_\_

**Coach:** \_\_\_\_\_

**League Official:** \_\_\_\_\_