

**GIRL SCOUTS OF EASTERN OKLAHOMA  
COUNCIL ACCIDENT/INCIDENT & DAMAGE REPORT FORM**



Report Type: (Circle all that apply)    **ACCIDENT**    **INCIDENT**    **DAMAGE**

Date of Incident \_\_\_\_\_ Time \_\_\_\_\_  a.m.    p.m.    Date of Report \_\_\_\_\_

*(If applicable)*

Name of Injured \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  Staff    Visitor  
*Last                                  First                                  Middle*

Address \_\_\_\_\_ Phone \_\_\_\_\_  
*Number & Street                                  City                                  State                                  Zip                                  Area/Number*

If injured is a minor, name of parent/Guardian \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_  
*Number & Street                                  City                                  State                                  Zip                                  Area/Number*

Where did accident/incident/damage occur? (Be specific. Include location, campsite, etc. Use additional paper for diagrams)

\_\_\_\_\_  
\_\_\_\_\_

Names/Addresses of Witnesses (***Attach signed statements detailing accident/incident/damage***)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Describe accident/incident/damage in detail. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Was any equipment involved?    No     Yes—Explain \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Could accident/injury have been avoided/prevented?    No     Yes—How? \_\_\_\_\_

Emergency procedures followed at time of accident/incident \_\_\_\_\_

By whom? \_\_\_\_\_

Were GSEOK Emergency Contact Persons notified?    No     Yes – By    Writing     Phone     Other \_\_\_\_\_

By whom? \_\_\_\_\_ Title \_\_\_\_\_ Date and Time \_\_\_\_\_

GSEOK Emergency Contact Person(s) notified (Name, Position and Date Notified)

\_\_\_\_\_

**MEDICAL REPORT INFORMATION** (If applicable)

If treatment was given, where was it given? \_\_\_\_\_

by whom? \_\_\_\_\_

If yes, describe treatment given \_\_\_\_\_

Was injured retained overnight in hospital?  No  Yes – Hospital? \_\_\_\_\_

Where? \_\_\_\_\_ Date \_\_\_\_\_  Out-patient  In-patient

Name of physician in attendance \_\_\_\_\_

Date released from hospital \_\_\_\_\_ Released to  Home  Other \_\_\_\_\_

Comments \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Additional notes and comments** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**INSURANCE NOTIFICATION**

- 1.  Individual's Insurance                       Council              Date \_\_\_\_\_ By \_\_\_\_\_
- 2.  Health Insurance                               Council              Date \_\_\_\_\_ By \_\_\_\_\_
- 3.  Liability Insurance                               Council              Date \_\_\_\_\_ By \_\_\_\_\_
- 4.  Worker's Compensation                       Council              Date \_\_\_\_\_ By \_\_\_\_\_

Report Submitted by: _____ Position _____ Date _____ <div style="text-align: center; margin-top: 5px;"><i>Signature</i></div>
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***For Office Use:***

Report Received By: \_\_\_\_\_ Date: \_\_\_\_\_

*Signature*

Please attach other testimonies or documents as needed.