

Group Accident Record Sheet

Name : _____ Group : _____

Date : _____ Time : _____

Location of accident : _____

How the accident happened : _____

Materials used in treatment : _____

Name of person who treated this person : _____

Did the person have any external treatment ?
(*No* or *Doctors* , *Dentist* , *Hospital* , _____)

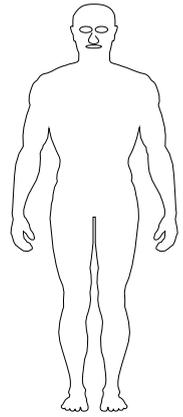
Any other details : _____

***Please make sure this form is kept somewhere centrally within your group,
and if needed, the parent or carer is informed of the accident
when the young person is collected.***

Designed by
Stuart Leacy

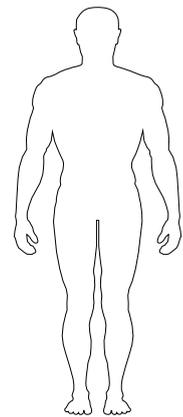
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Front of person



Need to circle where

Back of person



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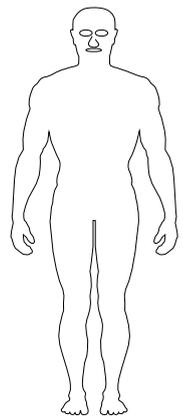
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