INJURY/SICKNESS REPORT

DATE: _____

TIME: _____

EVENT/LOCATION: _____

ATHLETE'S NAME: _____

ATHLETE'S TEAM NAME: _____

WITNESS NAME: _____

DESCRIPTION OF ACCIDENT/INJURY: _____

_____

_____

TREATMENT REQUIRED: _____

_____

_____

WHO ADMINISTERED: _____

SIGN BY WITNESS:_____

SIGNED BY COACH: _____

DATE: _____

*Please complete this form in case of sickness or injury and return it to any GMT Member or SOKS staff person.

MAIL FORM TO: Special Olympics Kansas
5280 Foxridge Dr
Mission, KS 66202