



Girl Scouts.

ACCIDENT/INCIDENT REPORT FORM

Fill out one form for each incident or person and submit to Girl Scouts of Michigan Shore to Shore Service Center within 48 hours of the incident.

Site Name _____ Date _____

Site Address _____

Number & Street City State Zip

Name of Person Involved _____ Age _____ Gender _____

Staff _____ Camper _____ Volunteer _____ Girl Scout _____

Grade Level: _____ Daisy _____ Brownie _____ Junior _____ Cadette _____ Senior _____ Ambassador

Address _____ Phone _____

Number & Street City State Zip Area/Number

Name of Parent/Guardian (if minor) _____

Address _____ Phone _____

Number & Street City State Zip Area/Number

E-mail _____

Name/Addresses of Witnesses (When relevant, attach signed statement.)

1. _____

2. _____

3. _____

Type of Incident _____ Behavior _____ Accident _____ Abuse Disclosure _____ Chronic Illness _____ Epidemic Illness _____ Other (describe) _____

Date of Incident/Accident _____ Hour _____ a.m. _____ p.m.

Day of the Week _____ Month _____ Date _____ Year _____

Describe the nature of the incident.

Describe what happened in detail. Use diagrams and additional paper as necessary.

Describe action taken and by whom.

Describe to whom the incident was reported.

Submitted by _____ Position _____ Phone _____ Date _____

MEDICAL REPORT OF ACCIDENT
Submit within 48 hours of the accident.

Person notified at the council office: _____

Were parents notified? ___ Yes ___ No By ___ Phone ___ Other _____

By Whom? _____ Title _____ When _____

Parent's Response _____

Where was treatment given? ___ at accident site ___ doctor's office ___ medical center ___ hospital

If treatment was given at the event/site, where? _____

By Whom? _____ Title _____ Date _____

Treatment given _____

Was injured retained overnight in camp health service? ___ Yes ___ No If yes, when? _____

Treatment given _____

By Whom? _____ Title _____ Date _____

Date released from health service _____

Released to ___ Camp Activities ___ Home ___ Other _____

Treatment given elsewhere than camp? ___ Yes ___ No Where? _____

By Whom? _____ Title _____ Date _____

Was injured retained overnight in hospital? ___ Yes ___ No If yes, which? _____

Where? _____ Date _____ ___ Out-patient ___ In-patient

Name of attending physician _____ Date released from hospital _____

Released to ___ Home ___ Camp ___ Council ___ Other _____

Comments/directions _____

Persons notified such as Camp Director/Council Staff, etc.

Name	Position	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe any contact made with/by the media regarding this situation _____

SIGNED _____ POSITION _____ DATE _____

Insurance Notification: 1. ___ Parents By ___ Parent ___ Council Date _____
 2. ___ Council GSUSA or ___ Council liability
 3. ___ Worker's Compensation

Mail or bring your completed form to:

Grand Rapids Service Center
3275 Walker Avenue NW
Grand Rapids, MI 49544

Muskegon Service Center
1217 E. River Road
Muskegon, MI 49445

Traverse City Service Center
1820 Oak Hollow Drive
Traverse City, MI 49686