INJURY/ILLNESS REPORT

Name of Injured/Ill Person: _____

Phone #: _____ Age: _____ DOB: _____ Gender: *M* *F*

Email: _____ USCB Status: *Student* *Faculty* *Staff* *Guest Other:* _____

Local Address: (circle one) *on-campus / off-campus* _____

Street/Dorm Name Room # City State

Injury/Illness Information

Occurred During (list sport): Intramural Sports: _____ Sport Clubs: _____ Other: _____

Date of Injury/Illness: _____ Location (Building/Room/Field): _____

Body Part Injured: _____ Side: *R* *L* *B*

Subjective: (What happened?)

_____

_____

Response: (What did you do?)

_____

_____

Name of Staff Responding: _____

Signature of Campus Recreation Staff Responding: _____ Date: _____

Please remember to complete the form on the back*

EMERGENCY MEDICAL SERVICES
ELECTION FORM

Is there an obvious serious injury?	Yes ___ No_ No	(if yes, call 911 immediately)
Is the patient conscious?	Yes ___ No ___	(if no, call 911 immediately)
Ambulatory (are they able to move)?	Yes ___	(if no, call 911 immediately)

If 911 is called: Time Called:_____Time Arrived: _____

If there is **no reason to call 911**, advise the patient as follows and initial:

_____ If you so desire and are able, you may provide your own transportation to a local hospital emergency room at this time.

_____ If immediate medical treatment is desired, an EMS ambulance will be called. EMS will transport all patients to a local hospital emergency room for treatment.

_____ There are charges for both EMS and/or emergency room services. The patient may be responsible for payment of and charges which exceed their health insurance coverage limits.

Ask the patient if they desire EMS to be contacted. Have the patient complete the Patient Election section of the EMS Election Form and comply with the patient's request.

Election: I have been advised of options concerning medical care for my injury or illness and make the following election: (initial/sign below).

_____ I request that Emergency Medical Services be summoned to provide me medical assistance. I understand I may be transported to a local hospital emergency room for treatment. I will assume responsibility for any charges associated with this request which exceed my health insurance coverage.

_____ I do not wish Emergency Medical Services to be contacted to provide medical assistance or to provide transportation to a local hospital emergency room. I release the University of South Carolina and it's employee's from any liability arising out of my decision not to summon EMS to provide medical assistance or transportation in connection with the injury or illness reported above.

_____	_____	_____	_____
Patient Signature	*Witness Signature*	*Witness Name (Printed)*	*Witness Phone #*

****If 911 Is Called (Police, Fire or Ambulance) Please Notify Lindsey Logue 843-368-3624**