



Girl Scouts of Western Washington
Incident Report Form

This form MUST be sent to Girl Scouts of Western Washington on the 1st business day after the incident. Send forms to:
Girl Scouts of Western Washington, ATTN: Insurance, 5601 6th Ave S, Suite 150, Seattle, WA 98108
Fax: 206.633.5099 Email: insurance@GirlScoutsWW.org

Where did the incident occur: Date of Incident: Time:

Address (if not a GSWW property):

City: State: Zip: Phone:

Type of incident: [] accident [] injury [] illness [] death [] behavioral [] near-miss
[] other (please specify):

Affected Person's Name: Age: Phone:

Address: City: State: Zip:

Email:

Parent/Guardian Name: Phone:

Address: City: State: Zip:

Witnesses / Others Affected: (please attach a separate sheet with names, addresses, phone #, email)

Name: Phone: Email:

Name: Phone: Email:

Description of Incident: (describe location, activity, and step by step sequence of events. Include a separate sheet with diagram if needed)

Did the incident result in an injury or illness requiring first aid or medical attention? [] YES [] NO

(if YES, please complete medical attention detail section on back)

If NO, what action was taken:

Did the incident result in any property damage: [] YES [] NO

(if YES, please complete property damage detail section on back)

Was any equipment involved in the incident: What

What (if any) unsafe conditions / behavior contributed to the incident:

How could the incident have been prevented:

Which Emergency Procedures were followed in responding to this incident?

[] Applied First Aid [] Called Emergency Medical Services [] BOTH

[] Reported to Girl Scout office Who reported: To whom: When:

[] Contact parent/guardian Who contacted: When: How:

[] Secured scene for safety and further investigation

[] Other:

Describe any media contact with regard to this incident:

MEDICAL ATTENTION DETAIL

Describe Injury or Illness (visible signs/symptoms):

Injury classification: (circle one) SLIGHT (req. first aid only) MODERATE (req. medical attention) SEVERE (potentially life threatening) FATAL (death)

Affected person refused medical treatment: YES NO Explanation: _____

Was First Aid given at the scene: YES NO By Whom: _____

What kind: _____

Were Emergency Medical Services (EMS) called: YES NO By Whom: _____

Estimated elapsed time between injury and First Aid: _____ ...and arrival of EMS: _____

Was the affected person moved from the scene for medical care: YES NO By Whom: _____

To where: _____

What treatment(s) given: _____

By whom: _____ For how long: _____

Affected person was released to: return to activity / home / parent or guardian / EMS or hospital

Was affected person was taken to a hospital or other medical facility: YES NO By Whom: _____

Hospital/Facility Name: _____ Phone: _____ City: _____

Name of treating physician: _____ Date/Time Released: _____

Affected's medical insurance company name: _____ Phone: _____

PROPERTY DAMAGE DETAIL

Property Damaged in Incident: _____

Extent of Damage: _____

Non-GSWW property owner's name _____ Phone: _____
 (attach separate sheet if multiple owners/contacts)

Owner's Insurance Carrier: _____ Phone: _____

Submitted by: (please print) _____ Phone : _____

Signature: _____ Date: _____

Staff use only

Notified Agency	Date	By Whom	Entered in Log	Date	By Whom
Affected Person's Insurance			OSHA Log		
GSWW Insurance Carrier			GSWW Incident Log		
Worker's Comp / L & I			Property or Site Incident Log		