

CCYFL Field Injury Report



Team Name _____

Division: _____

Head Coach: _____

Phone: _____

Parent Name: _____

Phone: _____

Patient Name	Age	Date	Time
List any Allergies: _____		Medications: _____	

VITAL SIGNS

TEMP	PULSE	RESP	BP

CHIEF COMPLAINT

Treatment:
Impression:

Was EMS Called	Yes	No
Was Parent/Guardian Notified	Yes	No
Was Patient Sent to Hospital	Yes	No

EMS Signature: _____

Parent Signature: _____

Coach Signature: _____