

MTB RACE ACCIDENT REPORT

PATIENT INFORMATION

Day/Month/Year:

Name: _____	Local Address: _____	Time of Incident _____ : _____
Address: _____	_____	Age: _____ DOB _____
Postal Code: _____	_____	Male <input type="checkbox"/> Female <input type="checkbox"/>
Province: _____	_____	Height: _____ Weight: _____
Telephone: _____	_____	BNL Member # _____
		Race License # _____

Occupation: _____

CHIEF COMPLAINT

	L	R		L	R		L	R		L	R		L	R	
Foot			Thigh			Chest			Shoulder			Wrist			Face
Ankle			Hip			Back			Upper Arm			Hand			
L Leg			Upper Abd			Neck			Lower Arm			Thumb			Medical Injury
Knee			Lower Abd			Clavicle			Elbow			Head			No Injury

TREATMENT PROTOCOL

Fracture	Sprain	Wound	Bruise	Cardiac	Illness	Concussion	Other:
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SIGNS & SYMPTOMS

	Allergies						
	Medications						
	Medical History						
Vital Signs: Time	Pulse	Resp	Pupils	Skin	LOC	Pain /10	BP
Vital Signs: Time	Pulse	Resp	Pupils	Skin	LOC	Pain /10	BP

FIRST AID

At the Scene: Time In: _____ Time Out: _____	Base/Clinic: Time In: _____ Time Out: _____		
_____	_____		
_____	_____		
Medication Given:	Dose	Time	By:

INCIDENT

Patient's Description of Incident:

Previous Injury	Parent/Guardian	Patient	I Refuse Treatment	Signed X
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WITNESS

Witness: _____ Collision with: _____	Witness: _____ Collision with: _____
Name: _____	Name: _____
Address: _____	Address: _____
Phone: _____ Relationship: _____	Phone: _____ Relationship: _____

LOCATION

Description of Location: _____ _____	Flat Terrain	Jumps
	Rocky	Obstacle
	Up Hill	Muddy
	Down Hill	Wet
	Single Track	Off Marked Trail

WEATHER LIGHT TEMP C ACTIVITY INVOLVEMENT COLLISION

Clear	Sharp	21 to 30	Cross Country	Recreation	Rider
Overcast	Flat	11 to 20	Short Track	Competition	Race Official
Fog	Limited Visibility	1 to 10	Down Hill	Training	By Stander
Raining	Dark	-5 to 0	Slalom	Jumping	Natural Object
Snowing	White Outs	-10 to -6	Trials	Other:	Other Object

HISTORY

Beginner	Practice / Familiarization Lap:	Yes	No	Lap # _____
Intermediate	Equipment:	Own	Borrowed	
Advanced	Helmet:	Yes	No	
Expert	Pedals:	Clip	Clipless	No Binding

TRANSPORT

Patroller Information

FROM BASE:	TO:	Name:	ID Number:
Private Car	Home	Name:	ID Number:
Company Vehicle	Doctor	Name:	ID Number:
Taxi	Hospital	Name:	ID Number:
Ambulance	Rest	Form Completed By (Print Name)	Signed
Code	Riding		X
			Date