

# FÉDÉRATION INTERNATIONALE DE GYMNASTIQUE



Please report any injury that requires active treatment or alters gymnastics training or competition.  
This document must be filled in by the official medical staff of the competition and under strict confidentiality.  
The eventual use of information for statistics must be strictly anonymous.

## Injury Report Form - 2021

Competition: ..... Country: .....

Date (DD/MM/YYYY): ..... / ..... / .....

Name of the gymnast (First name / Last name): .....

Date of birth (DD/MM/YYYY): ..... / ..... / ..... Gender: M ☐ F ☐

National Federation: .....

### 1. DISCIPLINE

MAG ☐  
RGI ☐

WAG ☐  
RGG ☐

TRA ☐  
AER ☐

TUM ☐  
ACRO ☐

DMT ☐  
PK ☐

GFA ☐

### 2. APPARATUS

Beam ☐

Uneven Bars ☐

Floor Exercise ☐

Pommel Horse ☐

Rings ☐

Vault ☐

Horizontal Bar ☐

Parallel Bars ☐

Ball ☐

Rope ☐

Ribbon ☐

Clubs ☐

Hoop ☐

Double Mini-trampoline ☐

Trampoline ☐

Tumbling ☐

Other ☐

Specify: .....

### 3. MECHANISM AND CIRCUMSTANCES OF THE ACCIDENT

Gymnast Error ☐ Apparatus deficiency ☐ Other ☐ Specify: .....

Manufacturer of the apparatus concerned: .....

Describe the skill performed: .....

Describe the mechanism of the accident: .....

(Use the official video if registered) .....

### 4. TIME AND SCHEDULE

Time difference between the home location and the location of the competition (+/-): .....

Day of the accident with regard of the arrival day at the competition: (D1, D2, D3, etc): .....

Time (24h clock): ..... : .....

Period of the accident:

No relation with sports practice ☐

Training ☐  
Warm-up ☐

Competition: Qualification ☐  
Final ☐

### 5. VENUE CONDITIONS – ENVIRONMENT

Comfortable ☐

Not comfortable ☐

Name of the gymnast (First name / Last name): .....

## 6. DIAGNOSIS / TYPE OF INJURY(IES)

### Area(s) of the body affected:

Finger <input type="checkbox"/>	Head <input type="checkbox"/>	Cervical Spine <input type="checkbox"/>	Hip <input type="checkbox"/>
Hand <input type="checkbox"/>	Face <input type="checkbox"/>	Thoracic Spine <input type="checkbox"/>	Thigh <input type="checkbox"/>
Wrist <input type="checkbox"/>	Nose <input type="checkbox"/>	Lumbar Spine <input type="checkbox"/>	Knee <input type="checkbox"/>
Forearm <input type="checkbox"/>	Eye <input type="checkbox"/>	Chest <input type="checkbox"/>	Leg <input type="checkbox"/>
Elbow <input type="checkbox"/>	Ear <input type="checkbox"/>	Abdomen <input type="checkbox"/>	Ankle <input type="checkbox"/>
Arm <input type="checkbox"/>	Teeth <input type="checkbox"/>		Foot <input type="checkbox"/>
Shoulder <input type="checkbox"/>	Mouth <input type="checkbox"/>		Heel <input type="checkbox"/>
Clavicle <input type="checkbox"/>			Toe <input type="checkbox"/>
Other <input type="checkbox"/>	Specify: .....		

LEFT ☐

RIGHT ☐

## 7. TYPE OF INJURY

Fracture <input type="checkbox"/>	Strain <input type="checkbox"/>	Sprain <input type="checkbox"/>	Hematoma <input type="checkbox"/>
Dislocation <input type="checkbox"/>	Tear <input type="checkbox"/>	Open Wound <input type="checkbox"/>	Soft Tissue Injury <input type="checkbox"/>
Other <input type="checkbox"/>	Specify: .....		

### Detail the diagnosis:

Recurrence of a former injury: ☐

Exacerbation of a chronic pathology: ☐

Details: .....

## 8. TREATMENT

Immediate Care:	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Follow up Care:	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Extended Care:	YES <input type="checkbox"/>	NO <input type="checkbox"/>
None <input type="checkbox"/>		

### Seen by:

Emergency staff ☐ Surgeon ☐ Doctor ☐ Physiotherapist ☐ First Aider ☐

### Medical examination:

XR ☐ MRI ☐ Echography ☐ Other ☐ Specify: .....

Comments of results: .....

Hospital ☐ Emergency / Resuscitation care ☐ Length of the stay

### Treatment:

Medical surgery on the spot ☐ Comment and details: .....

Decision to treat at home ☐

## 9. OUTCOME

Retirement of the competition	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Continue the competition with a reduced level of practice	YES <input type="checkbox"/>	NO <input type="checkbox"/>

General Observations / Remarks: .....

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Name of the gymnast (First name / Last name): .....

**10. EVALUATION AND PROGNOSTIC** *(These evaluation does not commit the evaluator)*

Without any unforeseeable complication

Evaluation of the injury recovery for daily life: .....

Evaluation of the training come back: .....

Evaluation of the competition return: .....

**11. GENERAL OBSERVATION / REMARK / CONCLUSION**

General Observations / Remarks: .....

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Name of the medical officer writing out this document: .....

Email of the medical officer: .....

Title: .....

Date (DD/MM/YYYY): ..... Signature: .....

**Please send this form to FIG IMMEDIATELY after the end of the competition under strict medical confidentiality to FIG at the attention of:**

FIG Anti-doping and Medical Manager: [lvidmer@fig-gymnastics.org](mailto:lvidmer@fig-gymnastics.org)

Fax: +41 21 321 55 29

*In case of the gymnast or the National Federation refuses the examination and treatment by the medical staff of the organization, please write however the information that you can obtain and take the legal precaution*

**12. THIS BOX HAS TO BE FILLED BY FIG ONLY**

Level of performance of the athlete: .....

General Observations / Remarks: .....

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