

CONFIDENTIAL

Please report any incident that requires active treatment or alters gymnastics training or competition

Competition: Country:

Date: / / (dd/mm/yyyy) Time: : 24-hour

Name of the Gymnast (first/last name): Gender: F ☐ M ☐

Date of birth (dd/mm/yyyy):

National Federation:

1. DISCIPLINE

MAG ☐ WAG ☐ TRA ☐ TUM ☐ DMT ☐

AER ☐ ACRO ☐ GFA ☐ RG ☐

2. APPARATUS

Beam <input type="checkbox"/>	Rings <input type="checkbox"/>	Horizontal Bar <input type="checkbox"/>	Ball <input type="checkbox"/>	Hoops <input type="checkbox"/>	Trampoline <input type="checkbox"/>
Floor <input type="checkbox"/>	Uneven Bars <input type="checkbox"/>	Parallel Bars <input type="checkbox"/>	Rope <input type="checkbox"/>	Clubs <input type="checkbox"/>	Tumble Track <input type="checkbox"/>
Pommel Horse <input type="checkbox"/>	Vault <input type="checkbox"/>		Ribbon <input type="checkbox"/>		Double Mini <input type="checkbox"/>
Other <input type="checkbox"/>	Specify	<input type="text"/>			

3. ACCIDENT CIRCUMSTANCES/MECHANISM

Gymnast Error ☐ Apparatus Related problem ☐ Other, specify:

Manufacturer of the Apparatus Concerned

Describe the situation + incident

Describe skill performed

4. TIME OF SESSION AND EVENT

No relation with sport ☐ Training ☐ Warm-up ☐

Competition { Qualification ☐ Final ☐

5. VENUE CONDITIONS - ENVIRONMENT

Comfortable ☐ Not comfortable ☐

Specify

6. DIAGNOSIS/TYPE OF INJURY/IES

Area(s) of the body affected:

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

Other ☐ Specify

Right ☐ Left ☐

1st time/new ☐ Re-injury ☐

Type of injury:

Fracture <input type="checkbox"/>	Strain <input type="checkbox"/>	Sprain <input type="checkbox"/>	Haematoma <input type="checkbox"/>
Dislocation <input type="checkbox"/>	Rupture <input type="checkbox"/>	Open Wound <input type="checkbox"/>	Soft Tissue Injury <input type="checkbox"/>
Other <input type="checkbox"/> Specify <input type="text"/>			

7. TREATMENT

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

8. OUTCOME

Seen by: Doctor ☐ Physio ☐ Sports Trainer ☐ First Aider ☐ Radiologist ☐

Hospital:

Examination YES ☐ NO ☐

Hospitalisation YES ☐ NO ☐

Continued Training YES ☐ NO ☐

Continued Competition YES ☐ NO ☐

General Observations/Remarks:

Name Title

Signature

Please send this form to FIG IMMEDIATELY after the end of the competition to the attention of the President of the FIG Medical Commission.

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