

FÉDÉRATION INTERNATIONALE DE GYMNASTIQUE



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

Medical Injury Report Form - 2017

Competition: Country:

Date (DD/MM/YYYY): / / Time (24h clock): :

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 ☐

GFA ☐

2. APPARATUS

Beam ☐ Uneven Bars ☐ Floor Exercise ☐ Pommel Horse ☐ Rings ☐
Vault ☐ Horizontal Bar ☐ Parallel Bars ☐ Rope ☐ Ribbon ☐
Clubs ☐ Hoop ☐ Ball ☐ Double Mini-trampoline ☐
Trampoline ☐ Tumbling ☐
Other ☐ Specify:

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 sports ☐

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"/> Hand <input type="checkbox"/> Wrist <input type="checkbox"/> Forearm <input type="checkbox"/> Elbow <input type="checkbox"/> Arm <input type="checkbox"/> Shoulder <input type="checkbox"/> Clavicle <input type="checkbox"/> Other <input type="checkbox"/>	Head <input type="checkbox"/> Face <input type="checkbox"/> Nose <input type="checkbox"/> Eye <input type="checkbox"/> Ear <input type="checkbox"/> Teeth <input type="checkbox"/> Mouth <input type="checkbox"/>	Cervical Spine <input type="checkbox"/> Dorsal Spine <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/>	Hip <input type="checkbox"/> Thigh <input type="checkbox"/> Knee <input type="checkbox"/> Leg <input type="checkbox"/> Ankle <input type="checkbox"/> Foot <input type="checkbox"/> Heel <input type="checkbox"/> Toe <input type="checkbox"/>	
Specify:				
LEFT <input type="checkbox"/>		RIGHT <input type="checkbox"/>		
1 st time / new <input type="checkbox"/> Re-injury <input type="checkbox"/>				
Type of injury: Fracture <input type="checkbox"/> Strain <input type="checkbox"/> Sprain <input type="checkbox"/> Hematoma <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:				
7. 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"/>				
8. OUTCOME				
Seen by: Doctor <input type="checkbox"/> Physio <input type="checkbox"/> Sports Trainer <input type="checkbox"/> First Aider <input type="checkbox"/> Radiologist <input type="checkbox"/>				
Hospital: YES <input type="checkbox"/> NO <input type="checkbox"/> Continued Training: YES <input type="checkbox"/> NO <input type="checkbox"/> Continued Competition: YES <input type="checkbox"/> NO <input type="checkbox"/>				
General Observations / Remarks:				

Name of the medical officer:

Title:

Email of the medical officer:

Date: Signature:

Please send this form to FIG IMMEDIATELY after the end of the competition under medical confidentiality

Email: lvldmer@fig-gymnastics.org
michel.leglise@ffgym.fr

Fax: +41 21 321 55 29