

FEDERATION INTERNATIONALE DE GYMNASTIQUE



CONFIDENTIAL

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

Gymnast Injury Report Form

Competition: _____ Country: _____
Date: ____ / ____ / ____ (dd/mm/yyyy) Time: ____ (24h clock)
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 ☐ Floor ☐ Pommel Horse ☐ Rings ☐ Uneven Bars ☐ Vault ☐
Horizontal Bar ☐ Parallel Bars ☐
Clubs ☐ Hoop ☐ Ball ☐ Rope ☐ Ribbon ☐
Trampoline ☐ Tumble Track ☐ Double Mini ☐
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 ☐ Competition ☐
Warm-up ☐ 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"/>	Head <input type="checkbox"/>	Cervical Spine <input type="checkbox"/>	Hip <input type="checkbox"/>
Hand <input type="checkbox"/>	Face <input type="checkbox"/>	Dorsal 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 _____		

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"/>	_____		

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 ☐ Physio ☐ Sports Trainer ☐ First Aider ☐ Radiologist ☐

Hospital:

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

email: lvidmer@fig-gymnastics.org fax: +41 21 321 55 29