

This form is to be completed and submitted to the council staff representative within 24 hours.

This report is due within 24 hours via email to the Chief Administrative Officer, Kara Fraser ([Kara.Fraser@gswny.org](mailto:Kara.Fraser@gswny.org)) and the Chief Executive Officer, Alison Wilcox ([Alison.Wilcox@gswny.org](mailto:Alison.Wilcox@gswny.org)). **After report is emailed, it must be mailed (US Mail) to:** GSWNY-Attn.: Kara Fraser, CAO-4433 Genesee Street, Suite 101, Buffalo, NY 14225

Date of Accident / Incident:	Time:	a.m.	p.m.
Type of Incident:	Accident / Injury	Illness	Behavioral Other

Program / Event Name:	Date(s) of Event:
Type of Event:	Troop / Group Service Unit Council
Name of Location of Event:	
Address:	
City:	State: Zip:

Name of Person Involved:	Age (if minor):
Description of Person Involved:	Girl Adult Non-Member Girl Non-Member Adult
Address:	
City:	State: Zip:
Phone:	Social Security Number (if known):
<b>If registered member:</b> Service Unit:	Troop / Group#:
Name of Parent(s) / Guardian(s), if minor:	
Address:	
City:	State: Zip:
<b>Phone Numbers:</b> Home:	Work: Cell:

Name / Address/ Phone # of Witnesses:
#1:
#2:
#3:

Describe the sequence of events in detail ( <i>be specific i.e. Broke right wrist or tripped and bruised left upper arm</i> ):
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Was the person involved in the Girl Scout activity at the time?	Yes	No
Was there equipment involved?	Yes	No If yes, what kind:
Did the accident/incident occur while traveling to or from the site of the activity?	Yes	No

## Parent Notification / Response

Were the parents/guardians notified of the accident / incident?	Yes	No
How were the parents/guardians notified?	Phone	Other:
Who notified the parents/guardians? (Name & Title):		
When were the parents/guardians notified?		
Parents'/Guardians' Response:		

## Emergency Response / Treatment

Describe the emergency procedures that were followed:		
By whom? Title:		
Was treatment given at site?	Yes	No
If yes, what kind of treatment (at site):		
Did the person receive treatment elsewhere? Yes No		
If yes, where?	Doctor's Office	Hospital / ER / Clinic
Doctor's Name:		Doctor's Phone:
Doctor's Address:		
Hospital/Clinic Name:		Hospital/Clinic Phone:
Hospital/Clinic Address:		

Is the person covered by health insurance?	Yes	No
If yes, what kind:	Insurance Policy #:	
Is the person covered by additional Girl Scout Mutual of Omaha insurance?	Yes	No
Describe the follow-up plan in detail:		

Name of the person completing this report:			
Address:			
City:		State:	Zip:
<b>Phone Numbers:</b> Home:		Work:	Cell:

Signature of person completing this report:

Date:

Signature of Council Representative:

Date: