

Injury Report Form

Event: _____ Date: _____

Location: _____
(City, County, State, SCA Territory)

Marshal-in-Charge: _____ Phone: _____

Injured Party:

Legal Name: _____

Phone: _____ SCA Name: _____

Address: _____

Description of Injury: _____

Apparent cause and circumstances of injury: _____

Treatment:

Treated at site by:

(Legal Name, SCA Name)

Treatment Administered: _____

Additional Treatment by hospital or physician (if known): _____

Comments by Marshal: _____

Signed: _____

(Legal Name)

(SCA Name)