



Northwest Territories SOCCER ASSOCIATION

If injury occurred, please check the following (check all that apply):

<input type="checkbox"/> No First-Aid was administered	<input type="checkbox"/> First-Aid Administered	<input type="checkbox"/> No CPR Administered
<input type="checkbox"/> CPR Administered (If administered for how long?)		
<input type="checkbox"/> No EMS Contacted	<input type="checkbox"/> EMS Contacted	

3. WHAT PART OF THE BODY WAS AFFECTED? (tick appropriate answers)

Head	Trunk	Internal	Arm	Hand	Leg	Foot
<input type="checkbox"/> Eye	<input type="checkbox"/> Neck	<input type="checkbox"/> Heart	<input type="checkbox"/> Left	<input type="checkbox"/> Left	<input type="checkbox"/> Left	<input type="checkbox"/> Left
<input type="checkbox"/> Ear	<input type="checkbox"/> Hip	<input type="checkbox"/> Lungs	<input type="checkbox"/> Right	<input type="checkbox"/> Right	<input type="checkbox"/> Right	<input type="checkbox"/> Right
<input type="checkbox"/> Nose	<input type="checkbox"/> Chest	<input type="checkbox"/> Systemic	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Thumb	<input type="checkbox"/> Knee	<input type="checkbox"/> Great Toe
<input type="checkbox"/> Mouth	<input type="checkbox"/> Stomach		<input type="checkbox"/> Upper Arm	<input type="checkbox"/> Fingers	<input type="checkbox"/> Lower Leg	<input type="checkbox"/> Other Toes
<input type="checkbox"/> Teeth	<input type="checkbox"/> Groin		<input type="checkbox"/> Elbow		<input type="checkbox"/> Ankle	
<input type="checkbox"/> Face	<input type="checkbox"/> Back		<input type="checkbox"/> Forearm		<input type="checkbox"/> Thigh	
<input type="checkbox"/> Skull	<input type="checkbox"/> Multiple		<input type="checkbox"/> Wrist			

Please indicate on the drawing where the injury occurred:

FRONT

BACK

Name (Print):	Witness' Name (Print):
Signature:	Witness' Signature:
	Witness Contact Number:
NWTSA Office Use Only	
Reviewed by:	Date:
Entered on Database:	Follow-up Investigation Required:
Recommendation:	
Signature:	Date: