

Section 1: Your Details

Name* _____

Email* _____

Telephone* _____

Role _____

Section 2: Where and when did it happen?

Venue Name* _____

Date _____

Approx. Time _____

Where did it happen?

Enclosed field Outdoor arena Classroom/Hall XC course Stable/yard
 Off road hacking/Road hacking Show Ground Lorry/Car park Camp site/field
 Indoor arena Other

Weather ConditionsSunny Windy Cloudy Snowy Rainy Icy Other **Details of Accident:****Section 3: Who was involved?**

Name* _____ Date of Birth _____

Branch* _____ Membership no/bib no _____

Next of Kin name* _____ Tel. _____

Email _____

Was the Person....

Participating Volunteering Spectating Coaching Official/Stewarding
 Fence Judge Groom/Helping Arena Party Third Party Other

What Happened?Mounted Fell off Kicked/impact by horse Unmounted -crush/impact Unmounted -lifting Mounted-Horse, Slip/trip, fall Unmounted - slip, trip, fall Bitten by horse Other

Details of Injury	Not Applicable <input type="checkbox"/>	Bruising <input type="checkbox"/>	Internal injuries <input type="checkbox"/>	Crush Injuries <input type="checkbox"/>
Head injury <input type="checkbox"/>	Illness <input type="checkbox"/>	Cut/laceration <input type="checkbox"/>	Sprain/strain <input type="checkbox"/>	Injury to bones /fracture <input type="checkbox"/>
Unknown <input type="checkbox"/>	Other <input type="checkbox"/>	Dislocation <input type="checkbox"/>		

Location of Injury	Not Applicable <input type="checkbox"/>				
Head <input type="checkbox"/>	Stomach <input type="checkbox"/>	Rh finger(s) <input type="checkbox"/>	Right Leg <input type="checkbox"/>	Rt ankle <input type="checkbox"/>	Eyes <input type="checkbox"/>
Neck <input type="checkbox"/>	Shoulder <input type="checkbox"/>	Lh finger(s) <input type="checkbox"/>	Left Leg <input type="checkbox"/>	Lt ankle <input type="checkbox"/>	Ears <input type="checkbox"/>
Back <input type="checkbox"/>	Right arm <input type="checkbox"/>	Rt hand <input type="checkbox"/>	Rt wrist <input type="checkbox"/>	Nose <input type="checkbox"/>	Unknown <input type="checkbox"/>
Ribs <input type="checkbox"/>	Left arm <input type="checkbox"/>	Lt hand <input type="checkbox"/>	Lt wrist <input type="checkbox"/>	Mouth <input type="checkbox"/>	Other <input type="checkbox"/>

Who attended to the injured person?

Name of First Aider

/Medical Officer

First Aider <input type="checkbox"/>	Ambulance <input type="checkbox"/>	Telephone Number _____
Doctor <input type="checkbox"/>	Air Ambulance <input type="checkbox"/>	Email _____
Paramedic <input type="checkbox"/>	Other <input type="checkbox"/>	

Was the injured person allowed to continue?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Was the injured person taken to/advised to be taken to hospital?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Did the injured person have suspected or confirmed concussion?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Section 4: Type of Activity

Ridden Rally <input type="checkbox"/>	Competition <input type="checkbox"/>	Hack <input type="checkbox"/>	Team Training <input type="checkbox"/>	Camp <input type="checkbox"/>
Social Event <input type="checkbox"/>	Unmounted Care/Education <input type="checkbox"/>		Social Event <input type="checkbox"/>	Other <input type="checkbox"/>

What Type of Sport/Activity was taking place?

Dressage/flatwork <input type="checkbox"/>	Polo <input type="checkbox"/>	Tetrathlon/Tri - Shoot <input type="checkbox"/>	Games/organised activiy <input type="checkbox"/>
Endurance <input type="checkbox"/>	Polocrosse <input type="checkbox"/>	Tetrathlon/Tri -Ridden <input type="checkbox"/>	Stable Management <input type="checkbox"/>
Eventing - D <input type="checkbox"/>	Pony Racing <input type="checkbox"/>	Tetrathlon/Tri - Swim <input type="checkbox"/>	Free Play <input type="checkbox"/>
Eventing - SJ <input type="checkbox"/>	Show Jumping <input type="checkbox"/>	Tetrathlon/Tri -Run <input type="checkbox"/>	Other <input type="checkbox"/>
Eventing - XC <input type="checkbox"/>	Mounted Games <input type="checkbox"/>	Cross Country <input type="checkbox"/>	

Was the person riding/handling a horse/pony?Yes No **Were they?**

Wearing a properly secured riding hat?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Was it tagged?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Wearing a body protector?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Wearing an air jacket?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Section 5: Was a Horse involved?Yes No

Horse Name _____

Was the horse being:	Ridden <input type="checkbox"/>	Tied up <input type="checkbox"/>	Held <input type="checkbox"/>	Lunged <input type="checkbox"/>
Led <input type="checkbox"/>	Stabled/penned <input type="checkbox"/>	Groomed/handled <input type="checkbox"/>	Loaded/unloaded <input type="checkbox"/>	
Loose <input type="checkbox"/>	Tackedup/untaked <input type="checkbox"/>	other <input type="checkbox"/>		

To the best of your knowledge, has the horse been involved in a similar accident of this nature? Yes No

Was the horse/pony injured?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Was Veterinary treatment required?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Was another horse/pony involved?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Description of the accident:

Section 6: Was any third party property damaged as a result of the accident?Yes No **What was damaged?**Car Fencing Building horsebox/trailer Other

Property Owner Name _____ Tel no. _____

Email _____

Section 6: Witnesses

Name of witness _____ Tel: _____

Email: _____

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Notes:

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