

# Incident/Injury Report Form

Please Print

In the event of injury while volunteering,  
please notify City of Oakland staff immediately at  
[adoptaspot@oaklandca.gov](mailto:adoptaspot@oaklandca.gov), 510-238-7630.

|   |                               |   |        |
|---|-------------------------------|---|--------|
| Name of (Injured Person)  | Gender<br>M    F              | Birthday  | E-Mail |
| Address of Injured Person and Best Contact Phone Number (Include Area Code)   |                               |   |        |
| If Applicable, Parent's Name, Address, and Best Contact Phone Number (Include Area Code)  |                               |   |        |
| Date and Time of Accident   | Place where Accident Occurred |   |        |
| Type of Injury suspected if known (Check any that apply):<br>Bruise      Dislocation      Laceration      Concussion      Fracture      Sprain/Strain<br>Other(Specify)   |                               |   |        |
| Body Part Injured (Note side of Injury using "R" for Right side and "L" for Left Side)<br><input type="checkbox"/> Hand <input type="checkbox"/> Foot <input type="checkbox"/> Arm <input type="checkbox"/> Shoulder <input type="checkbox"/> Back <input type="checkbox"/> Head <input type="checkbox"/> Face <input type="checkbox"/> Foot <input type="checkbox"/> Leg <input type="checkbox"/> Chest <input type="checkbox"/> Eye<br>Other(Specify) |                               |   |        |
| Was First Aid rendered? Describe if yes:  |                               |   |        |
| Was an Ambulance recommended?      Yes      No  |                               |   |        |
| If yes, did the injured refuse?      Yes      No  |                               |   |        |
| Were teeth injured? If so, which ones?  |                               | Describe Condition of Injured Teeth Prior to Accident:<br>Whole, Sound, and Natural      Filled      Capped      Artificial |        |
| Did Injury Result in Death?      Yes      No  |                               |   |        |
| Describe How Accident Occurred – Give All Possible Details  |                               |   |        |
| Form completed by<br>Print Name _____ Signature _____<br>Date _____   |                               |   |        |