



# Gymnastics

## Gymnast injury report form



### CONFIDENTIAL

Please report any incident that requires active treatment or alters gymnastics training or competition

Competition:  Country:

Date:  /  /  (dd/mm/yyyy) Time:  :  24-hour

Name of the gymnast (first/last name):  Gender: F ☐ M ☐

Date of birth (dd/mm/yyyy):

National federation:

#### 1. DISCIPLINE

MAG ☐ WAG ☐ GR ☐ GT ☐

#### 2. APPARATUS

Beam <input type="checkbox"/>	Rings <input type="checkbox"/>	Horizontal bar <input type="checkbox"/>	Ball <input type="checkbox"/>	Hoop <input type="checkbox"/>	Trampoline <input type="checkbox"/>
Floor <input type="checkbox"/>	Uneven bars <input type="checkbox"/>	Parallel bars <input type="checkbox"/>	Ribbon <input type="checkbox"/>	Clubs <input type="checkbox"/>	
Pommel horse <input type="checkbox"/>	Vault <input type="checkbox"/>				
Other <input type="checkbox"/>	Specify	<input type="text"/>			
		<input type="text"/>			

#### 3. ACCIDENT CIRCUMSTANCES/MECHANISM

Gymnast error ☐ Apparatus related problem ☐ Other, specify:

Manufacturer of the apparatus concerned

Describe the situation + incident

Describe skill performed

#### 4. TIME OF SESSION AND EVENT

No relation with sport ☐ Training ☐ Warm-up ☐ Competition { Qualification ☐ Final ☐

#### 5. VENUE CONDITIONS - ENVIRONMENT

Comfortable ☐ Not comfortable ☐

Specify



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### 6. DIAGNOSIS/TYPE OF INJURY/IES

#### Area(s) of the body affected:

Finger <input type="checkbox"/>	Elbow <input type="checkbox"/>	Head <input type="checkbox"/>	Ear <input type="checkbox"/>	Cervical Spine <input type="checkbox"/>	Hip <input type="checkbox"/>	Foot <input type="checkbox"/>
Hand <input type="checkbox"/>	Arm <input type="checkbox"/>	Face <input type="checkbox"/>	Teeth <input type="checkbox"/>	Dorsal Spine <input type="checkbox"/>	Thigh <input type="checkbox"/>	Heel <input type="checkbox"/>
Wrist <input type="checkbox"/>	Shoulder <input type="checkbox"/>	Nose <input type="checkbox"/>	Mouth <input type="checkbox"/>	Lumbar spine <input type="checkbox"/>	Knee <input type="checkbox"/>	Toe <input type="checkbox"/>
Forearm <input type="checkbox"/>	Clavicle <input type="checkbox"/>	Eye <input type="checkbox"/>		Chest <input type="checkbox"/>	Leg <input type="checkbox"/>	
				Abdomen <input type="checkbox"/>	Ankle <input type="checkbox"/>	

Other ☐ Specify

Right ☐ Left ☐

1st time/new ☐ Re-injury ☐

#### Type of injury:

Fracture ☐ Strain ☐ Sprain ☐ Haematoma ☐

Dislocation ☐ Rupture ☐ Open wound ☐ Soft tissue injury ☐

Other ☐ Specify

### 7. TREATMENT

Immediate care	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="text"/>
Follow-up care	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="text"/>
Extended care	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="text"/>
None	<input type="checkbox"/>		

### 8. OUTCOME

Seen by: Doctor ☐ Physio ☐ Sports trainer ☐ First aider ☐ Radiologist ☐

#### Hospital:

Examination	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Hospitalisation	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Continued training	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Continued competition	YES <input type="checkbox"/>	NO <input type="checkbox"/>

#### General observations/remarks:

Name  Title

Signature

**Please send this form to FIG IMMEDIATELY after the end of the competition to the attention of the President of the FIG Medical Commission.**

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