Kingdom of Meridies
Injury Report

Event Name: _____

Event Address:_____

City: _____State: _____Zip Code: _____

Date of the Report: _____Date of the Injury: _____

Hosting Group Name: _____City: _____State: _____

Event Autocrat SCA Name: _____

Mundane Name: _____

Email:_____Phone: _____

Address: _____

City: _____State: _____Zip Code: _____

Host Group Seneschal SCA Name: _____

Mundane Name: _____

Email:_____Phone: _____

Address: _____

City: _____State: _____Zip Code: _____

Injured Individual SCA Name: _____

Mundane Name: _____

Email:_____Phone: _____

Address: _____

City: _____State: _____Zip Code: _____

Causes and Circumstances of Injury: _____

_____

Transferred to Facility: _____

Physician: _____Facility Address: _____

City: _____State: _____Zip Code: _____

Treatment at Facility: _____

_____

Autocrat Signature:_____Date: _____

Seneschal Signature:_____Date: _____

Injured's Signature: _____Date: _____

Please print clearly or type. Report must be included with Event or Quarterly Report. If injuries require offsite transportation, must be filed within 24 hours.