The following forms will be used as part of the District's safety and risk management program:

Exhibit A: Workers' Compensation First Report of Injury — 2 pages

Exhibit B: Health Services Report of Accident and Injury — 1 page

Exhibit C: Health Services Report of Unusual Occurrence — 1 page

Exhibit D: Record of Hazard Observed — 1 page

Exhibit E: Health Services Report of Animal Bite — 1 page

EXHIBIT A

WORKERS' COMPENSATION
FIRST REPORT OF INJURY

GENERAL	Employer Name Spring Branch ISD		Carrier/Administration Claim Number	Report Purpose Code	
	Street Address 955 Campbell Road		Jurisdiction	Jurisdiction Claim Number	
	City Houston		Insured Report Number		
	State Zip Code TX 77024		Employer's Location Address (if different)	Location #	
	SIC Code Employer FEIN 611110 74-6001379			Location Code	
CARRIER	**CLAIMS ADMIN**	Carrier (Name, Address & Phone No.) Texas Association of School Boards P.O. Box 2010 Austin, TX 78767-2010	Policy Period To Check If Appropriate ☐ Self Insurance	Claims Administrator (Name, Address, Phone No.) Texas Association of School Boards Risk Management Fund P.O. Box 2010 Austin, TX 78767-2010	
		Carrier FEIN 74–2275519	Policy/Self-Insured Number	Administrator FEIN	
		Agent Name & Code Number			

EMPLOYER	Name (Last, First, Middle)	Date of Birth	Social Security No.	Date Hired	State of Hire
	Address (incl. ZIP)	Sex	Marital Status	Occupation/Job Title	
				Employment Status	
	Phone	# of Dependents		NCCI Class Code	

WAGE	Rate	Per ☐Hourly ☐ Daily	Month Bi-Weekly	# of Days Worked/Week	# of Hours Per Week	Full Pay for Day of Injury?

<table>
<tr><td rowspan="8">O
C
C
U
R
R
E
N
C
E</td><td>Time Employee Began Work</td><td>Date of Injury/Illness</td><td>Time of Occurrence</td><td>Last Work Date</td><td>Date Employer Notified</td><td>Date Disability Began</td></tr>
<tr><td colspan="2">Contact Name/Phone Number</td><td colspan="2">Type of Injury/Illness</td><td colspan="2">Part of Body Affected</td></tr>
<tr><td colspan="3">Did injury/illness exposure occur on employer’s premise?</td><td colspan="3">Type of Injury/Illness</td></tr>
<tr><td colspan="3">Department or location where accident or illness exposure occurred.</td><td colspan="3">All equipment, materials, or chemicals employee was using when accident or illness exposure occurred.</td></tr>
<tr><td colspan="3">Specific activity the employee was engaged in when the accident or illness exposure occurred.</td><td colspan="3">Work process the employee was engaged in when the accident or illness exposure occurred.</td></tr>
<tr><td colspan="4">How injury or illness/abnormal health condition occurred. Describe the sequence of events and include any objects or substances that directly injured the employee or made the employee ill.</td><td colspan="2">Cause of injury</td></tr>
<tr><td colspan="2">Date Returned to Work</td><td colspan="2">If Fatal, Give Date of Death</td><td colspan="2">Were Safeguards or Safety Equipment Provided?

Were They Used?</td></tr>
<tr><td rowspan="2">T
R
E
A
T
M
E
N
T</td><td colspan="2">Physician/Health Care Provider (Name & Address)

Dr.</td><td colspan="2">Hospital (Name & Address)</td><td>Initial Treatment</td></tr>
<tr><td rowspan="2">O
T
H
E
R</td><td colspan="4">Witness (Name & Phone #)</td><td rowspan="2"></td></tr>
<tr><td>Date Administrator Notified</td><td>Date Prepared</td><td colspan="2">Preparer’s Name & Title</td><td>Phone Number</td></tr>
</table>

EXHIBIT B

HEALTH SERVICES
REPORT OF INJURY OR ACCIDENT

Name _____ Grade ___ Sex ___ Age ___ Birthdate _____
Address _____ Apt. _____ Zip _____ School _____
Parent's Name _____ Telephone _____
Person in Charge _____ Witness _____
Location of Accident _____ Time _____ Date of Accident _____
Cause of Accident _____

NATURE OF INJURY

☐ Abrasion ☐ Aspiration
☐ Bleeding ☐ Bruise/Contusion
☐ Bite ☐ Insect Sting
☐ Burn ☐ Inflammation
☐ Cut ☐ Laceration
☐ Edema ☐ Concussion (?)
☐ Hematoma ☐ Fracture (?)
☐ Ingestion ☐ Dislocation (?)
☐ Pain ☐ Sprain (?)
☐ Puncture ☐ Strain (?)
☐ Other _____

BODY PART(S) INJURED

PHYSICAL ASSESSMENT

Pulse _____ Respirations _____
B.P. _____ Pupils _____
☐ Alert ☐ Oriented
☐ Medical Care Advised
Comment _____
_____

CARE ADMINISTERED

Cleansed _____ ☐ Sling
Ointment _____ ☐ Splint
☐ Dressing ☐ Elevated ☐ Rest
☐ Heat ☐ Cold ☐ Direct Pressure
Other _____
_____

FOLLOW-UP

☐ District Infectious Disease Procedures employed.
Disposition _____
Status _____
_____
_____
_____
_____

_____
Caregiver's Signature Title Date Time

EXHIBIT C

HEALTH SERVICES
REPORT OF UNUSUAL OCCURRENCE

Student _____ Date _____

School _____ Nurse _____

Important: The confidentiality of this report must be ensured. Record complete, factual and applicable information including dates, times and names of persons involved.

DESCRIPTION OF INCIDENT _____

SPECIFIC OBSERVATIONS/VERBAL QUOTATIONS _____

ACTIONS TAKEN/REFERRAL _____

FOLLOW UP _____

EXHIBIT D

RECORD OF HAZARD OBSERVED

Reported by: (optional) _____ Date: _____

Reported to: _____ Date: _____

Nature of hazard: (Describe—act, equipment, situation, etc.)

_____

_____

_____

_____

Location of hazard: (Be specific, i.e., custodial closet, west wing, XYZ Elementary School)

_____

_____

_____

_____

Action: (By supervisor)

_____

_____

_____

_____

_____ _____
Supervisor Signature Date

_____ _____
Safety Committee Chairperson Date

EXHIBIT E

Health Services
Report of Animal Bite

Name _____ Age _____ Sex _____ Grade _____

Address _____ Apt ___ Zip _____ Birthdate _____

Parent's Name _____ Telephone _____

School _____ Telephone _____

School Address _____ Zip _____

DESCRIPTION OF INCIDENT

Site of incident _____ Date _____ Time _____

Nature of wound: Puncture Laceration Scratch

Other wounds: _____ Body Part(s) bitten _____

Circumstances of bite _____

DESCRIPTION OF ANIMAL

Animal Involved: Dog Cat Other

Hair of animal: Long Short Color _____

Breed: _____ Age _____ Sex _____ Weight _____

Unusual behavior of the animal _____

Animal last seen _____

Owner of animal _____ Telephone _____

Address _____ Apt _____ Zip _____

REPORT TO LOCAL ANIMAL CONTROL AGENCY

Agency Name _____

Reported by _____ Title _____

Date reported _____ Time reported _____