BILLINGS PUBLIC SCHOOLS

Student Accident Form

This report should be completed for injuries which require immediate or future intervention. The original copy is to be sent to the Business Office; the copy retained in the School.

Name of Injured: _____ Birthdate: _____

Address: _____ Phone: _____ Sex: _____

School: _____ Grade: ____ Student: ☐

Date of Injury: _____ Time of Day: _____ Activity Involved: _____

Describe accident: (Specific location, condition of premises, equipment involved, what happened)

_____

_____

_____

First Aid action taken: _____

By whom: _____ Parent notified: Yes ☐ No ☐ By: _____

Medical care recommended: Yes ☐ No ☐ Explain: _____

Where taken after accident: (Specify home, physician, hospital, home and address):

_____

How transported: _____ By whom: _____

Witnesses familiar with circumstances:

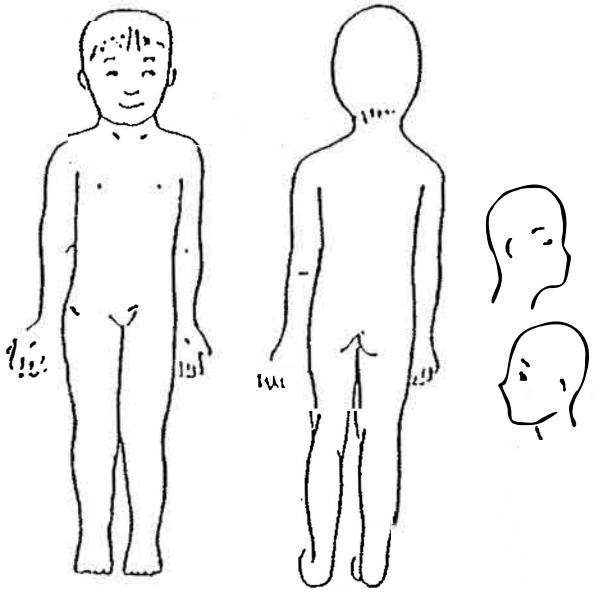
Name _____ Address _____ Phone _____

Name _____ Address _____ Phone _____

REPORT OF CONDITION AT TIME OF ACCIDENT

Check appropriate observation: Normal ☐ Alert ☐ Overactive ☐ Listless ☐ Unable to arouse ☐

Skin condition: Within Normal Limits ☐ Pale ☐ Dry ☐ Moist ☐ Cool ☐ Warm ☐



Indicate on diagram location of injury. Describe appearance of injury. _____

_____

_____

Any pertinent health history, characteristics, or limitations:

_____

_____

_____

Follow up information: _____

_____

_____

_____

Report completed by: _____ Date: _____

Caregiver's Signature: _____

Title: _____ Date: _____

Principal's Signature: _____ Date: _____

S-3/95-00025/8-92

Parent/Guardian Notified of Student Accident Insurance YES___ NO___ By: _____ DECLINED___

Parent/Guardian Notified of K & K Concussion YES___ NO___ By: _____ DECLINED___