Injury Report Form

This form to be completed by district personnel only

SCHOOL/SITE _____ **INJURED PERSON** _____

Exact Area/Room _____ Date of Incident _____ Time _____ ☐ am ☐ pm

Supervisor in Charge _____ Date of Birth _____ ☐ Male ☐ Female

Supervisor Title _____ Phone _____

If Witnessed/Name(s) _____ Address _____

Describe event, actions, conditions and what injured person was doing before incident. If sport injury, specify sport _____

Injury – describe in detail

Care Provided – describe in detail (continue on back if needed)

Care Provided By _____ ☐ School Nurse If Not/Position _____

☐ **STUDENT INJURY** Grade _____ Pupil # _____ Grad Year if HS Student _____

☐ Notified Parent/Guardian / Name _____ Phone _____

☐ Home w Parent/Guardian ☐ Home with Other / Name _____

☐ **EMPLOYEE INJURY – Employee injuries must be reported within 7 days**

Occupation _____ Time Work Begins _____ Work Ends _____

☐ Sent Home Driven By (Name) _____

☐ Time lost from work If yes, number of days gone _____

☐ **VISITOR INJURY** ☐ Parent ☐ Other / Specify _____

☐ **911 & MEDICAL PROVIDER INFORMATION**

☐ 911 Called If 911 Transport - Name of ER _____ ☐ Admitted Overnight

☐ Sent to Medical Provider Name of Medical Provider _____

Reporting Employee _____ _____ _____

Print Name **Signature** **Date**

Principal Review _____ _____ _____

Print Name **Signature** **Date**

Send Copies To: Principal and/or Department Supervisor
If Blood Exposure or Head Injury Report Attached – Health Services
If Staff Injury – Human Resources Dept - Workers Comp
If Student or Visitor Injury - Risk Management Department

This form does not comply with RCW 4.96.020 for the filing of a Claim for Damages