

Accident Report

Report Completed By: _____ Title: _____

Name of School		School Principal	
Name of Injured Party		Date of Accident	Time of Accident <input type="checkbox"/> am <input type="checkbox"/> pm
Address		Age/Birthdate	Sex Grade or Position
Is student covered by Student Accident Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		Status <input type="checkbox"/> Employee <input type="checkbox"/> Student <input type="checkbox"/> Visitor <input type="checkbox"/> Trespasser <input type="checkbox"/> Other describe _____	
Description of Accident (How did the accident happen? What was the injured person doing? What tool, machine or equipment was involved? What teacher, supervisor or administrator was responsible for the area? Who witnessed the accident?) (Attach separate sheet if needed.) _____ _____ _____			
Witness		Address	
		Telephone #	
Location		Type of Injury	
Body Part(s) Affected			
<input type="checkbox"/> Athletic Field	<input type="checkbox"/> Maintenance Area	<input type="checkbox"/> Scratch	<input type="checkbox"/> Sprain/Strain
<input type="checkbox"/> Abdomen	<input type="checkbox"/> Finger	<input type="checkbox"/> Nose	
<input type="checkbox"/> Bus	<input type="checkbox"/> Office/Lobby	<input type="checkbox"/> Fracture	<input type="checkbox"/> Cut/Puncture
<input type="checkbox"/> Ankle	<input type="checkbox"/> Foot	<input type="checkbox"/> Shoulder	
<input type="checkbox"/> Bus Stop	<input type="checkbox"/> Playground	<input type="checkbox"/> Bruise	<input type="checkbox"/> Choking
<input type="checkbox"/> Arm	<input type="checkbox"/> Hand	<input type="checkbox"/> Tooth	
<input type="checkbox"/> Cafeteria	<input type="checkbox"/> Restroom	<input type="checkbox"/> Burn Chemical/Heat/Carpet	<input type="checkbox"/> Poisoning/Overdose
<input type="checkbox"/> Back	<input type="checkbox"/> Head	<input type="checkbox"/> Wrist	
<input type="checkbox"/> Classroom	<input type="checkbox"/> Sidewalk	<input type="checkbox"/> Concussion/Head Injury	<input type="checkbox"/> Electrical Shock
<input type="checkbox"/> Chest	<input type="checkbox"/> Knee		
<input type="checkbox"/> Hallway	<input type="checkbox"/> Theater or Stage	<input type="checkbox"/> Bite – Animal/Insect/Human	<input type="checkbox"/> Dislocation
<input type="checkbox"/> Ear	<input type="checkbox"/> Leg		
<input type="checkbox"/> Library	<input type="checkbox"/> Weight Room	<input type="checkbox"/> Dizziness/Fainting	
<input type="checkbox"/> Eye	<input type="checkbox"/> Mouth		
<input type="checkbox"/> Gymnasium / Locker Room		<input type="checkbox"/> Face	<input type="checkbox"/> Neck
<input type="checkbox"/> Stairs (Inside/Outside)			
<input type="checkbox"/> Other (If off premises – specify location)	<input type="checkbox"/> Other (describe)	<input type="checkbox"/> Other (describe)	
Immediate Action Taken			
<input type="checkbox"/> None			
<input type="checkbox"/> First Aid provided. Given by: _____			
<input type="checkbox"/> Medical Ambulance called. Time of Call: _____ By: _____			
<input type="checkbox"/> School Nurse notified. Time of Call: _____ By: _____			
<input type="checkbox"/> Parent/Guardian notified. Time of Call: _____ By: _____			
<input type="checkbox"/> Name of Parent/Guardian notified: _____			
<input type="checkbox"/> Parents/Guardian Telephone Number: _____ (Home) _____ (Work)			
<input type="checkbox"/> Injured person released to <input type="checkbox"/> Self <input type="checkbox"/> Home <input type="checkbox"/> Class <input type="checkbox"/> Physician <input type="checkbox"/> Hospital <input type="checkbox"/> Other			
<input type="checkbox"/> Time released: _____			

Date: _____ Telephone Number: _____

RELATED PROCEDURE

03.14 AP.1

NOTE: This report is for record purposes only and does not constitute the admission of liability on the part of the school system or any employee thereof. A734601

For Central Office Use Only:	Forwarded to General Liability Insurance Carrier on _____
	Forwarded (as determined by Superintendent) to Board Counsel on _____

Review/Revised:06/26/13