

Student Injury Report Form

Washington Jr./Sr. High School

Student Name _____ Age _____ Grade _____ () Male () Female
 Date of Injury _____ Time of Injury _____

Incident Location: Gym Bus # () Stairs
 Hallway Parking Lot Classroom ()
 Other _____

Body Part Injured:	<u>Head</u>	<u>Trunk</u>	<u>Extremities</u>	<u>Other</u>
	<input type="checkbox"/> Ear	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Ankle	<input type="checkbox"/> Lower Arm
	<input type="checkbox"/> Eye	<input type="checkbox"/> Back	<input type="checkbox"/> Elbow	<input type="checkbox"/> Lower Leg
	<input type="checkbox"/> Face	<input type="checkbox"/> Chest	<input type="checkbox"/> Finger	<input type="checkbox"/> Thumb
	<input type="checkbox"/> Head	<input type="checkbox"/> Groin	<input type="checkbox"/> Foot	<input type="checkbox"/> Toe
	<input type="checkbox"/> Neck	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Hand	<input type="checkbox"/> Upper Arm
	<input type="checkbox"/> Scalp		<input type="checkbox"/> Hip	<input type="checkbox"/> Upper Leg
	<input type="checkbox"/> Nose		<input type="checkbox"/> Knee	<input type="checkbox"/> Wrist

Type of Injury Suspected:

<input type="checkbox"/> Laceration	<input type="checkbox"/> Abrasion	<input type="checkbox"/> Bruise/Contusion
<input type="checkbox"/> Sprain/Strain	<input type="checkbox"/> Dislocation	<input type="checkbox"/> Fracture
<input type="checkbox"/> Concussion	<input type="checkbox"/> Burn	<input type="checkbox"/> Other: _____

Explanation of Incident:

<input type="checkbox"/> Collision with Person	<input type="checkbox"/> Collision with Obstacle ()
<input type="checkbox"/> Hit with Object ()	<input type="checkbox"/> Fall
<input type="checkbox"/> Injury to Self Object used ()	<input type="checkbox"/> Other ()

Surface:

<input type="checkbox"/> Blacktop	<input type="checkbox"/> Dirt/Mud	<input type="checkbox"/> Grass	<input type="checkbox"/> Gym floor
<input type="checkbox"/> Carpet	<input type="checkbox"/> Gravel	<input type="checkbox"/> Mats	<input type="checkbox"/> Concrete
<input type="checkbox"/> Ice/Snow	<input type="checkbox"/> Sand	<input type="checkbox"/> Other	_____

First Aid Given:

<input type="checkbox"/> Washed wound	<input type="checkbox"/> Pressured applied	<input type="checkbox"/> Applied dressing
<input type="checkbox"/> Immobilized	<input type="checkbox"/> Ice	<input type="checkbox"/> Observed
<input type="checkbox"/> Other Explain: _____		

Action Taken: Phone call to: _____ Relationship to student _____
 Student released to: _____ for: Visit with Dr. ER Home
 Transported per 911 call to: _____

Supervision: Was staff present: Yes No Name and title: _____

Further description of injury: _____

Follow Up: Seen by _____ Return appt. _____ No return appt. _____
 No treatment sought Other _____

Days Absent: ½ 1 Other _____ Date returned to school _____
 Restrictions per physician (attach copy any written orders) _____

Signed(person filing report) _____ Title _____ Date _____

Principal signature _____ Date _____