



Subject to Board Policy EBBB-R: A report must be completed and submitted in a timely manner. This report may be completed by the school nurse, coach or other staff person who handles the incident.

STUDENT INCIDENT REPORT

Revised 7/2016

SCHOOL: _____ **DATE OF INCIDENT:** _____ **TIME OF INCIDENT:** _____

STUDENT INFORMATION:				
Student's Name: _____				
Age: _____	Date of Birth: _____	Sex: <input type="checkbox"/> Male	<input type="checkbox"/> Female	Grade: _____
Home Address: _____			Home Phone: _____	
City/State/Zip: _____				
Parent/Guardian Name: _____			Work Phone: _____	

INCIDENT INFORMATION:				
Incident occurred at: School <input type="checkbox"/> School bus <input type="checkbox"/> Other <input type="checkbox"/> If other, where? _____				
Incident occurred during: Class <input type="checkbox"/> Recess <input type="checkbox"/> Lunch <input type="checkbox"/> Phys Ed <input type="checkbox"/> Other _____				

How did the incident occur? _____				
Were other students involved? Yes <input type="checkbox"/> No <input type="checkbox"/> Were there witnesses? Yes <input type="checkbox"/> No <input type="checkbox"/>				
List below: _____				
Name: _____		Name: _____		
Home Phone: _____		Home Phone: _____		

Information below is NOT a medical diagnosis, but is based on presented symptoms and student's description.

NATURE OF INJURY:		PART OF BODY INJURED: (indicate left, right, upper, lower, etc.)		
<input type="checkbox"/> Abrasion	<input type="checkbox"/> Dislocation (possible)	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Face	<input type="checkbox"/> Mouth
<input type="checkbox"/> Amputation	<input type="checkbox"/> Fracture (possible)	<input type="checkbox"/> Ankle	<input type="checkbox"/> Finger	<input type="checkbox"/> Neck
<input type="checkbox"/> Bite	<input type="checkbox"/> Puncture	<input type="checkbox"/> Arm	<input type="checkbox"/> Foot	<input type="checkbox"/> Nose
<input type="checkbox"/> Bruise/Swelling	<input type="checkbox"/> Respiratory	<input type="checkbox"/> Back	<input type="checkbox"/> Hand	<input type="checkbox"/> Scalp
<input type="checkbox"/> Burn	<input type="checkbox"/> Scratches	<input type="checkbox"/> Chest	<input type="checkbox"/> Head	<input type="checkbox"/> Shoulder
<input type="checkbox"/> Concussion (possible)	<input type="checkbox"/> Seizure	<input type="checkbox"/> Elbow	<input type="checkbox"/> Knee	<input type="checkbox"/> Tooth
<input type="checkbox"/> Cut/Laceration	<input type="checkbox"/> Sprain/Strain	<input type="checkbox"/> Eye	<input type="checkbox"/> Leg	<input type="checkbox"/> Wrist
<input type="checkbox"/> Other (specify) _____		<input type="checkbox"/> Other (specify) _____		

IMMEDIATE ACTION TAKEN:	DESCRIBE INJURY/CARE/FOLLOW-UP
<input type="checkbox"/> First-aid treatment-by whom? _____	
<input type="checkbox"/> Parent called-by whom? _____	
<input type="checkbox"/> Physician called-by whom? _____	
<input type="checkbox"/> Ambulance called-by whom? _____	
<input type="checkbox"/> Police called-by whom? _____	
<input type="checkbox"/> Sent home-by whom? _____	

Reported by: _____ Position: _____
 Phone/Ext: _____ Date of Report: _____

WITHIN 24 HOURS OF INCIDENT, EMAIL COMPLETED FORM TO DOROTHY BARNHART, SANDY CHANEY & SCHOOL NURSE OR FAX TO DISTRICT RISK MANAGEMENT OFFICE (613-6169)