

SELAH

STUDENT ACCIDENT REPORT FORM

School District _____

TO BE USED FOR ALL ACCIDENTS

PERSON COMPLETING FORM _____

NAME _____ HOME ADDRESS _____ TIME OF ACCIDENT _____

SCHOOL _____ GENDER M F AGE _____ GRADE _____ DATE _____POSITION OF PERSON INVOLVED: STUDENT VISITOR OTHER _____

NATURE OF INJURY	BODY PART INJURED	LOCATION	SPECIFY SCHOOL ACTIVITY	
(CHECK ALL THAT APPLY) ACCIDENTAL <input type="checkbox"/> ACCIDENTAL CONTACT <input type="checkbox"/> ANIMAL BITE/STING <input type="checkbox"/> ASSAULT <input type="checkbox"/> ASSAULT W/ WEAPON <input type="checkbox"/> ATHLETIC INJURY (AFTER SCHOOL) <input type="checkbox"/> ATHLETIC INJURY (DURING SCHOOL) <input type="checkbox"/> BIO-HAZARD EXPOSURE <input type="checkbox"/> BURN/SCALD <input type="checkbox"/> CHEMICAL EXPOSURE <input type="checkbox"/> CHIPPED TOOTH <input type="checkbox"/> CHOKING <input type="checkbox"/> ELECTRICAL INJURY <input type="checkbox"/> EYE INJURY <input type="checkbox"/> FALL FROM ELEVATED SURFACE <input type="checkbox"/> FRACTURE <input type="checkbox"/> HIT BY FOREIGN OBJECT <input type="checkbox"/> HORSEPLAY <input type="checkbox"/> HUMAN BITE <input type="checkbox"/> ILLNESS <input type="checkbox"/> LACERATION <input type="checkbox"/> MEDICAL CONDITION <input type="checkbox"/> PUNCTURE WOUND <input type="checkbox"/> SMASHED <input type="checkbox"/> STRUCK STATIONARY OBJECT <input type="checkbox"/> TRIP/SLIP <input type="checkbox"/> VOCATIONAL <input type="checkbox"/>	R <input type="checkbox"/> L <input type="checkbox"/> ANKLE <input type="checkbox"/> ARM <input type="checkbox"/> BACK <input type="checkbox"/> EAR <input type="checkbox"/> ELBOW <input type="checkbox"/> EYE <input type="checkbox"/> FACE <input type="checkbox"/> FINGER <input type="checkbox"/> FOOT <input type="checkbox"/> HAND <input type="checkbox"/> HEAD <input type="checkbox"/> HIP <input type="checkbox"/> KNEE <input type="checkbox"/> LEG <input type="checkbox"/> MOUTH <input type="checkbox"/> NOSE <input type="checkbox"/> WRIST <input type="checkbox"/> OTHER _____	AUDITORIUM <input type="checkbox"/> BUS/BUS STOP <input type="checkbox"/> CAFETERIA <input type="checkbox"/> CLASSROOM <input type="checkbox"/> GYMNASIUM <input type="checkbox"/> HALLWAY <input type="checkbox"/> LIBRARY <input type="checkbox"/> LOCKER ROOM <input type="checkbox"/> OFF CAMPUS <input type="checkbox"/> PARKING LOT <input type="checkbox"/> PLAYGROUND <input type="checkbox"/> RESTROOM <input type="checkbox"/> SCHOOL GROUNDS <input type="checkbox"/> _____SHOP <input type="checkbox"/> _____FIELD <input type="checkbox"/> OTHER _____		
NAME OF SUPERVISOR IN CHARGE WHEN ACCIDENT OCCURRED _____ PHONE NUMBER _____ WAS SUPERVISOR PRESENT AT TIME OF ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			DID THE STUDENT REQUIRE MEDICAL ASSISTANCE? <input type="checkbox"/> Y <input type="checkbox"/> N	WERE PARENTS NOTIFIED? <input type="checkbox"/> Y <input type="checkbox"/> N
ACTION TAKEN FIRST AID TREATMENT <input type="checkbox"/> SENT TO SCHOOL NURSE <input type="checkbox"/> AMBULANCE CALLED <input type="checkbox"/> SENT TO HOSPITAL <input type="checkbox"/> NO TREATMENT <input type="checkbox"/> CALLED PARENT/GUARDIAN <input type="checkbox"/> SENT HOME <input type="checkbox"/> OTHER _____ <input type="checkbox"/>	BY WHOM		SPECIFY ACTION TAKEN	
WITNESS NAME _____ ADDRESS _____ PHONE _____ NAME _____ ADDRESS _____ PHONE _____				
DESCRIPTION OF ACCIDENT USE REVERSE SIDE IF NECESSARY _____ Building Principal Signature				