

Ohio Department of Health Student Injury Report

Student Information

| | | | |
|---------------|-------|---|------------------|
| Name | | Date of incident | |
| Date of birth | Grade | <input type="checkbox"/> Male <input type="checkbox"/> Female | Time of incident |

Parent/guardian information

| | | | |
|---------|-------|------------------------|------------------------|
| Name(s) | | Work phone () | |
| Address | | Home phone () | |
| City | State | ZIP | Cell phone () |

School information

| | |
|--------|-------------------|
| School | Phone () |
|--------|-------------------|

Location of incident check appropriate box

- Athletic field Cafeteria Gymnasium Parking lot Restroom Vocation shop/lab
 Bus Classroom Hallway Playground Stairway
 Other *explain*

Time of incident check appropriate box

- Recess Lunch P.E. class In class (not P.E.) Class change Field trip
 Before school After school Unknown
 Other *explain*

Athletic practice/session:

- Athletic team competition Intramural competition

Equipment

- No equipment involved Equipment involved *describe*

Surface check all that apply

- Asphalt Concrete Gravel Ice/snow Mat(s) Synthetic surface Wood chips/mulch
 Carpet Dirt Gymnasium floor Lawn/grass Sand Tile
 Other *specify*

Type of injury check all that apply

| | Head | Eye | Ear | Nose | Mouth/lips | Tooth/teeth | Jaw | Chin | Neck/throat | Collarbone | Shoulder | Upper arm | Elbow | Forearm | Wrist | Hand | Finger | Fingernail | Chest/ribs | Back | Abdomen | Groin | Genitals | Pelvis/hip | Leg | Knee | Ankle | Foot | Toe |
|-----------------|------|-----|-----|------|------------|-------------|-----|------|-------------|------------|----------|-----------|-------|---------|-------|------|--------|------------|------------|------|---------|-------|----------|------------|-----|------|-------|------|-----|
| Abrasion/scrape | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Bite | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Bump/swelling | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Bruise | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Burn/scald | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Cut/laceration | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Dislocation | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Fracture | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Pain/tenderness | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Puncture | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Sprain | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Other | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Contributing factors *check all that apply*

- | | | | | |
|--|--|---|---|---|
| <input type="checkbox"/> Animal bite | <input type="checkbox"/> Compression/pinch | <input type="checkbox"/> Fall | <input type="checkbox"/> Overextension/twisted | <input type="checkbox"/> Struck by object (bat, swing, etc) |
| <input type="checkbox"/> Collision with object | <input type="checkbox"/> Contact with hot or toxic substance | <input type="checkbox"/> Foreign body/object | <input type="checkbox"/> Physical Altercation | <input type="checkbox"/> Tripped/slipped |
| <input type="checkbox"/> Collision with person | <input type="checkbox"/> Drug, alcohol or other substance involved | <input type="checkbox"/> Hit with thrown object | <input type="checkbox"/> Struck by auto, bike, etc. | |
- Weapon specify Other explain

Description of the incident

Witnesses to the incident

Staff involved *check all that apply*

- | | | | | |
|--|--|------------------------------------|------------------------------------|--|
| <input type="checkbox"/> Assistant staff | <input type="checkbox"/> Cafeteria staff | <input type="checkbox"/> Nurse | <input type="checkbox"/> Secretary | <input type="checkbox"/> Other specify |
| <input type="checkbox"/> Bus driver | <input type="checkbox"/> Custodian | <input type="checkbox"/> Principal | <input type="checkbox"/> Teacher | |

Incident response *check all that apply*

| | | | |
|--|--|--|-----------------------|
| <input type="checkbox"/> First Aid | Time | By whom | |
| <input type="checkbox"/> Called 911 | Time | By whom | |
| <input type="checkbox"/> Parent/guardian notified | Time | By whom | |
| <input type="checkbox"/> Unable to contact parent/guardian | Time | By whom | |
| <input type="checkbox"/> Parents deemed no medical action necessary | <input type="checkbox"/> Returned to class | <input type="checkbox"/> Sent/taken home | Days of school missed |
| <input type="checkbox"/> Taken to health care provider / clinic/hospital/urgent care | Diagnosis | | Days of school missed |
| <input type="checkbox"/> Hospitalized | Diagnosis | | Days of school missed |
| <input type="checkbox"/> Restricted school activity | Explain | Length of time restricted | Days of school missed |
| <input type="checkbox"/> Other explain | | | |

Describe care provided to the student

Additional comments

| | |
|---|-----------|
| Signature of staff member completing form | Date/time |
| Nurse's signature | Date/time |
| Principal's signature | Date/time |