

STUDENT INCIDENT REPORT

Send to Risk Management Mail Code (714) or

Stacy.Cunningham@richlandone.org cc: Beverley.Leeper@richlandone.org

Name: School Date

Address: Phone: Time of Incident Location

Description of Incident:

<p>Other: <input type="text"/></p>	<p>Person Reporting/Responding to Incident (Print) <input type="text"/></p>
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Nature of Injury			Part of Body Injured		
<input type="checkbox"/> Abrasion	<input type="checkbox"/> Cut	<input type="checkbox"/> Scratch	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Face	<input type="checkbox"/> Leg
<input type="checkbox"/> Amputation	<input type="checkbox"/> Dislocation	<input type="checkbox"/> Shock	<input type="checkbox"/> Ankle	<input type="checkbox"/> Finger	<input type="checkbox"/> Mouth
<input type="checkbox"/> Asphyxiation	<input type="checkbox"/> Fracture	<input type="checkbox"/> Sprain	<input type="checkbox"/> Back	<input type="checkbox"/> Foot	<input type="checkbox"/> Nose
<input type="checkbox"/> Bite	<input type="checkbox"/> Laceration	<input type="checkbox"/> Splinter	<input type="checkbox"/> Chest	<input type="checkbox"/> Forearm	<input type="checkbox"/> Shoulder
<input type="checkbox"/> Bruise	<input type="checkbox"/> Poisoning	<input type="checkbox"/> Strain	<input type="checkbox"/> Ear	<input type="checkbox"/> Hand	<input type="checkbox"/> Teeth
<input type="checkbox"/> Burn	<input type="checkbox"/> Puncture		<input type="checkbox"/> Elbow	<input type="checkbox"/> Head	<input type="checkbox"/> Wrist
<input type="checkbox"/> Concussion	<input type="checkbox"/> Repetitive Stress Injury		<input type="checkbox"/> Eye	<input type="checkbox"/> Knee	

Did they go to school nurse for treatment? YES or NO

Was first aid administered? YES or NO If So, What?

Witness Name: Date: Phone:

Signature of Responder/Reporter: Date: Phone:

Signature of Principal: Date: Phone: