School District of Ashland

Student Injury Report

Please Type or Print

1. Complete within 24 hours of injury.
2. Sign and date the complete report.
3. Submit to building Principal.
4. Copy to District Office.

For District Office Use Only
Claim #
Claim Examiner

Student Name		Time of Injury AM PM	Date of Injury (mm/dd/ccyy)
Home Address		Work Telephone	Parent / Guardian Notified: ☐ Yes ☐ No
Birth Date	Grade / Homeroom Teacher	Home Telephone	Parent / Guardian Name: ______________________________

Was medical treatment required? ☐ Yes ☐ No First aid only? ☐ Yes ☐ No Was student taken home? ☐ Yes ☐ No	Name and Address of Treating Practitioner: Name and Address of Facility:

Exact location of where accident took place (inside, outside, building name, room, vehicle, etc):

Witnesses (names, addresses, work telephone numbers)

Injury Description – Describe activities when injury or illness occurred and what tools, machinery, objects, chemicals, etc. were involved.

What happened to cause this injury or illness? (Describe how the injury occurred)

In your opinion, what could be done to prevent other similar accidents?

Name of staff member completing this form:____

Please indicate the part of the body that was injured. (Check all that apply; thumb = finger1, great toe = toe1)

☐ Right Arm	☐ Left Arm	☐ Right Leg	☐ Left Leg	☐ Abdomen	☐ Upper ☐ Mid ☐ Lower
☐ Right Shoulder	☐ Left Shoulder	☐ Right Knee	☐ Left Knee	☐ Back	☐ Upper ☐ Mid ☐ Lower
☐ Right Elbow	☐ Left Elbow	☐ Right Ankle	☐ Left Ankle	☐ Head	☐ Right Eye ☐ Left Eye
☐ Right Wrist	☐ Left Wrist	☐ Right Foot	☐ Left Foot	☐ Nose	
☐ Right Hand	☐ Left Hand	☐ Right Toe	☐ Left Toe	☐ Mouth	
☐ Right Finger	☐ Left Finger	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5		☐ Neck	
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5				☐ Other (please specify):	

I certify that the above statements are true and accurate to the best of my knowledge.

Principal Signature ____ **Date** __________________________

School Office Use Only
Medical Treatment – Student Return to School Status / Diagnosis: