West Valley Central School
5359 School Street
West Valley, NY 14171
(716) 942-3293

REPORT OF STUDENT/PERSONAL INJURY

Date: _____
Name: _____ Age: ____ Grade: _____
Parent's Name: _____
Address: _____
Where did accident occur? _____
Date of accident: _____ Time: _____ AM/PM
Had student a right to be where he/she was when hurt? YES/NO
Name of supervisor present: _____
Was first aid rendered? YES/NO When: _____ By whom: _____
Taken to: __Hospital __Home __DR. __Med. Office __Ret'd to class
Parent/Guardian notified YES/ NO.
How were they notified _____ by whom _____
Nature and extent of injury: _____
_____
_____

Name and addresses of witnesses:
_____
_____

What was student doing? Give description of accident: (cause, machine or other equipment involved, other parties involved, conditions involved): _____
_____
_____
_____
_____

Date: _____ Signed: _____
Completed by Teacher/Staff

Date: _____ Signed _____
Principal/Superintendent

Comments: _____
_____
_____
_____