ACCIDENT REPORT

This form is to be completed by the appropriate employee(s) as soon as possible after an accident occurs.

District Name: Madison County Schools **School Name:** _____

Principal's Name: _____ **School Phone: (859)** _____ **Date Reported:** _____

Date of Accident: _____ **Time:** _____ ☐ **AM** ☐ **PM** **Supervising Employee:** _____

Claimant's Name: _____ _____ _____
Last Name First Name Middle Initial

Claimant's Address: _____ _____ _____ (859) _____
City State Zip Code Home/Cell Phone #

Claimant's Age: _____ Date of Birth: _____ Sex: ____ Grade: _____

Parent's Name (if student): _____ Work Phone Number ( ) _____

Nature of Injury

☐ Scratch ☐ Concussion
☐ Fracture ☐ Head Injury
☐ Bruise ☐ Sprain
☐ Burn ☐ Cut/Puncture
☐ Dislocation ☐ Bite
☐ Other: _____

Place of Accident

☐ Classroom ☐ Gymnasium
☐ Hallway ☐ Parking Lot
☐ Bathroom ☐ Sidewalk
☐ Cafeteria ☐ Stairs
☐ Playground ☐ Athletic Field
☐ Other: _____

Body Part Injured

☐ Ankle ☐ Foot ☐ Leg
☐ Arm ☐ Face ☐ Nose
☐ Back ☐ Finger ☐ Teeth
☐ Neck ☐ Hand ☐ Wrist
☐ Eye ☐ Knee ☐ Shoulder
☐ Other: _____

Describe accident and injury in detail (Attach additional sheet(s) if needed):

Were efforts made to contact the parent/guardian about the accident? ☐ ***Yes*** ☐ ***No***

Was first aid administered? ☐ ***Yes*** ☐ ***No*** ***By whom?*** _____

Was the student: ☐ ***Sent home*** ☐ ***Sent to physician*** ☐ ***Sent to hospital***

Is the student covered by Student Accident Insurance? Yes No If yes, please list the company name, address, and phone number. _____

IF MEDICAL OR HOSPITAL TREATMENT WAS REQUIRED, PLEASE COMPLETE THE FOLLOWING:
(Attach a copy of medical bills, if available)

Name and address of doctor or hospital: _____

Witness (Name, address & phone number): _____

_____ _____
Signature of Person Completing the Report ***Date***