Form # SHS 48
rev. 7/12

School City of East Chicago

Health Services

Accident Report

Name: _____ Date of Birth: _____ Date: _____

Address: _____ Phone: _____

_____

School: _____ Grade: _____ Time: _____

History of accident and place of occurrence: _____

_____

_____

_____ Abrasions

_____ Contusion

_____ Laceration

_____ Sprain and/or Suspicious Fracture

_____ Other

_____
Name of Employee - Witness to Accident

First Aid*

_____ Cleaned

_____ Sterile Dressing

_____ Ice Bag

_____ Parent Notified and Referred to Family Doctor

_____ Other

Remarks* _____

_____

_____

Copy of First Aid Form Attached? ☐ Yes ☐ No

Copy of Head Injury Attached? ☐ Yes ☐ No

Check* _____ RN

White - Health Services • Yellow - Nurse • Pink - Principal • Goldenrod - Parent or Workers Comp