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**CONFIDENTIAL - ATTORNEY/CLIENT
WORK PRODUCT PRIVILEGE**
This report is to be completed by school district employees. This form is a confidential, internal, document; its contents are not to be shared or copied for any persons who are not school district employees and/or their legal representatives.

CONFIDENTIAL SCHOOL ACCIDENT REPORT

IN CASE OF SERIOUS INJURIES A TELEPHONE REPORT IS TO BE MADE IMMEDIATELY

NOTE: The school employee either witnessing the accident or supervising at the time should complete and submit this form within 24 hours. Please type or print using ball point pen.

DATE OF REPORT		NAME OF SCHOOL	
ADDRESS OF SCHOOL (NUMBER, STREET, CITY AND ZIP CODE)			
NAME OF INJURED PERSON (LAST, FIRST, M.I.)		AGE	GRADE
		TELEPHONE NUMBER OF INJURED PERSON ()	
IS INJURED PERSON A MINOR <input type="checkbox"/> NO <input type="checkbox"/> YES	NAME OF PARENT OR LEGAL GUARDIAN		
ADDRESS OF PERSON INJURED (NUMBER, STREET, APARTMENT NUMBER, CITY, STATE AND ZIP CODE)			
WHERE DID ACCIDENT OCCUR		DATE (MONTH/DAY/YEAR)	TIME <input type="checkbox"/> AM <input type="checkbox"/> PM
DESCRIBE HOW ACCIDENT OCCURRED (USE FACTS ONLY; EXCLUDE OPINIONS AND/OR ASSUMPTIONS)			
FIRST AND LAST NAME OF PERSON IN CHARGE AT TIME OF ACCIDENT	TITLE OF PERSON (TEACHER, VOLUNTEER, ETC.)	WAS HE/SHE PRESENT AT THE TIME? <input type="checkbox"/> NO <input type="checkbox"/> YES	INJURED VIOLATED SCHOOL RULE? <input type="checkbox"/> NO <input type="checkbox"/> YES
NAME OF WITNESS(ES)	ADDRESS	TELEPHONE NO.	STATUS (Student/Volunteer, etc.)
		()	
		()	
APPARENT NATURE OF INJURY (PLEASE CHECK)		INJURED PART OF BODY (PLEASE CHECK)	
<input type="checkbox"/> Abrasion <input type="checkbox"/> Fracture <input type="checkbox"/> Strain/Sprain <input type="checkbox"/> Contusion <input type="checkbox"/> Cut <input type="checkbox"/> Dislocation <input type="checkbox"/> Internal <input type="checkbox"/> Concussion <input type="checkbox"/> Other (Explain) _____		<input type="checkbox"/> Head <input type="checkbox"/> Finger <input type="checkbox"/> Arm <input type="checkbox"/> Abdomen <input type="checkbox"/> Neck <input type="checkbox"/> Eye <input type="checkbox"/> Leg <input type="checkbox"/> Hand <input type="checkbox"/> Back <input type="checkbox"/> Chest <input type="checkbox"/> Face <input type="checkbox"/> Foot <input type="checkbox"/> Other (Explain) _____	
FIRST AID PROCEDURES USED		NAME OF PERSON WHO ADMINISTERED FIRST AID	
DISPOSITION OF INJURED AFTER ACCIDENT <input type="checkbox"/> Home <input type="checkbox"/> Doctor <input type="checkbox"/> Hospital <input type="checkbox"/> CLASS		WHO WAS NOTIFIED	
RELATIONSHIP TO INJURED			
IF INJURED PUPIL LEFT SCHOOL TO WHOM RELEASED		NAME AND ATTITUDE OF ANYONE CONTACTING SCHOOL	
STUDENT ACCIDENT BENEFITS AVAILABLE <input type="checkbox"/> NO <input type="checkbox"/> YES NAME OF COMPANY		REMARKS	
REMARKS CONTINUED			
NAME OF PERSON COMPLETING REPORT		STATUS	TELEPHONE NUMBER OF PERSON ()
ADDRESS OF PERSON (NUMBER, STREET, CITY, STATE AND ZIP CODE)			WAS PERSON AN EYE WITNESS? <input type="checkbox"/> NO <input type="checkbox"/> YES
SIGNATURE OF PERSON APPROVING REPORT		DATE SIGNED	