

**RSU NO. 5 STUDENT ACCIDENT/INJURY REPORT**

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

School/Location: \_\_\_\_\_ Coach/Staff: \_\_\_\_\_ Sport/Activity: \_\_\_\_\_

<b><u>Nature of Injury:</u></b>	
Abrasion/Skin	Puncture
Bone/Joint	Sprain
Breathing	Strain
Bump/Bruise	
Cut/Laceration	
Foreign Body	
Head Injury: Level of Consciousness	
How/Other:	

<b><u>Part of Body Injured:</u></b>	
Head/Face	L/R Ear
Abdomen	R/L Eye
Chest/Rib	R/L Arm/Elbow
Nose	R/L Shoulder
Mouth	R/L Knee
Teeth	R/L Hip
Back/Neck	R/L Foot/Ankle
Other:	

<b><u>First Aid Administered:</u></b>
Evaluated/Treated by Athletic Trainer
Ice
Compression
Wound Care
Fluids Administered
Elevation
Other:

<b><u>Disposition/Determination:</u></b>
Removal from Play
Returned to play
Called 911
Transported by Ambulance
Accompanied by: _____
Left Game/Practice with Parent
Referred to Physician
Other:

Parent/Guardian Notified: YES NO

Name of Parent/Guardian: \_\_\_\_\_

Name of Person Notifying: \_\_\_\_\_

Name of Person Reporting: \_\_\_\_\_ Date: \_\_\_\_\_

Athletic Trainer/Coach Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Administrator Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Copy Sent To:**

\_\_\_\_ Athletic Trainer    \_\_\_\_ School Nurse    \_\_\_\_ Athletic Director    \_\_\_\_ Superintendent's Office

**If a concussion is suspected:** The Concussion Management Protocol, Return-To-Learn, and Return-To-Sport Progressions must be activated, implemented, and followed per JJIF - STUDENT CONCUSSIONS AND OTHER HEAD INJURIES. Staff following Protocols must ensure that Protocols are current per Maine DOE Concussion Management Resource Guide (linked [HERE](#)).