

## Visitor INJURY/INCIDENT REPORT FORM

(Please complete for anyone who is not a paid KPS employee)

**Building/Location Where Incident Occurred:** \_\_\_\_\_

**Date of Incident:** \_\_\_\_\_ **Time of Incident:** \_\_\_\_\_

**Describe Specifically How the Injury Happened:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Witness(es) to Incident:** \_\_\_\_\_

**Accident  
Location:**

☐ Classroom # \_\_\_\_\_  
☐ Stairs  
☐ Sidewalk

☐ Playground  
☐ Hallway  
☐ Other \_\_\_\_\_

☐ Gym (non-PE)  
☐ Bus

**Explanation  
of Accident:**

☐ Collision with Person  
☐ Injury To Self  
☐ Other \_\_\_\_\_

☐ Collision with Obstacle  
☐ Fall

☐ Hit with Object

**Surface:**

☐ Blacktop  
☐ Carpet  
☐ Concrete  
☐ Other: \_\_\_\_\_

☐ Dirt  
☐ Pea gravel  
☐ Ice/Snow

☐ Grass  
☐ Mats  
☐ Sand

☐ Synthetic surface  
☐ Rubber tile  
☐ Wood products

**Type of  
Injury  
Suspected:**

☐ Laceration  
☐ Bruise/Contusion  
☐ Dislocation  
☐ Surface cut/Scratch

☐ Convulsion/Seizure  
☐ Discoloration  
☐ Fracture  
☐ Other: \_\_\_\_\_

☐ Bump  
☐ Sprain/Strain  
☐ Puncture

☐ Abrasion  
☐ Shock  
☐ Burn

Please complete back of this form

| Body Part Injured:       | Head     | Trunk                    | Extremities (indicate left or right) |                          |        |                          |           |
|--------------------------|----------|--------------------------|--------------------------------------|--------------------------|--------|--------------------------|-----------|
| <input type="checkbox"/> | Ear      | <input type="checkbox"/> | Abdomen                              | <input type="checkbox"/> | Ankle  | <input type="checkbox"/> | Lower arm |
| <input type="checkbox"/> | Eye      | <input type="checkbox"/> | Back                                 | <input type="checkbox"/> | Elbow  | <input type="checkbox"/> | Lower leg |
| <input type="checkbox"/> | Face     | <input type="checkbox"/> | Chest                                | <input type="checkbox"/> | Finger | <input type="checkbox"/> | Thumb     |
| <input type="checkbox"/> | Head     | <input type="checkbox"/> | Groin                                | <input type="checkbox"/> | Foot   | <input type="checkbox"/> | Toes      |
| <input type="checkbox"/> | Neck     | <input type="checkbox"/> | Shoulder                             | <input type="checkbox"/> | Hand   | <input type="checkbox"/> | Upper arm |
| <input type="checkbox"/> | Scalp    | <input type="checkbox"/> | Trunk                                | <input type="checkbox"/> | Hip    | <input type="checkbox"/> | Upper leg |
| <input type="checkbox"/> | Forehead |                          |                                      |                          |        | <input type="checkbox"/> | Knee      |
| <input type="checkbox"/> | Teeth    |                          |                                      |                          |        |                          |           |

|                              |                          |                  |                          |                        |                          |                |
|------------------------------|--------------------------|------------------|--------------------------|------------------------|--------------------------|----------------|
| Treatment Or First Aid Given | <input type="checkbox"/> | Ice              | <input type="checkbox"/> | Washed Wound           | <input type="checkbox"/> | Kept Immobile  |
|                              | <input type="checkbox"/> | Observed         | <input type="checkbox"/> | Stopped Bleeding       | <input type="checkbox"/> | Applied Splint |
|                              | <input type="checkbox"/> | Applied Dressing | <input type="checkbox"/> | Other (Please Explain) |                          |                |

Explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Treatment Administered By: \_\_\_\_\_

|               |                          |                                               |                          |                         |
|---------------|--------------------------|-----------------------------------------------|--------------------------|-------------------------|
| Action Taken: | <input type="checkbox"/> | None – Visitor OK to leave or resume activity | <input type="checkbox"/> | Transferred to Hospital |
|               | <input type="checkbox"/> | Called 911                                    | <input type="checkbox"/> | To ER                   |
|               | <input type="checkbox"/> | To Doctor                                     |                          |                         |
|               | <input type="checkbox"/> | Other _____                                   |                          |                         |

First Responder Name: \_\_\_\_\_ Date: \_\_\_\_\_

Visitor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Principal Signature \_\_\_\_\_ Date: \_\_\_\_\_

Send form to: Central Administration Office, Human Resources Department  
 320 West 24<sup>th</sup> St. Kearney, NE 68845