STUDENT ACCIDENT REPORT

SCHOOL INFORMATION
School: ____________________ School Telephone #: ( ) _________________________
Teacher (Home Room): ____________________

STUDENT INFORMATION
Student’s Full Name: ____________________ Date of Birth: ___________ Age: ____ Grade: _____
Parents / Guardian Name: ____________________ Telephone #: ____________________
Street Address: ____________________ Mailing Address: ____________________
City: ____________________ State: ___________ Zip Code: ___________

INJURY INFORMATION
Date of Injury: ____________________ Time: ____________________ AM ____ PM _____
Specific Nature of Injury: (Body Part):
_______________________________________________________________________________________________
Description of Accident: (What was student doing? Specify if tool, machine or equipment being used)
_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________

Person in Charge: ____________________ Title: ___________ Present at Scene: Yes ____ No _____
Specific Location of Accident: (Playground east side of slide, in hall outside room #, etc.)
Witnesses: (List name, address & telephone number - Attach separate sheet if necessary)
(1) __________________________________________________________________________________________
(2) __________________________________________________________________________________________

ACTION TAKEN
Type of First Aid Treatment Given: __________________________________________________________________________________________
Given by: __________________________________________________________________________________________
Student Sent Home? Yes ____ No _____ If so, by whom: __________________________________________________________________________________________
School Nurse, if involved: ___________ EMT’s, if involved: __________________________________________________________________________________________
Sent to Doctor: Yes ____ No ____ By Whom: ___________ Doctor: __________________________________________________________________________________________
Sent to Hospital: Yes ____ No ____ By Whom: ___________ Hospital: __________________________________________________________________________________________
Hospital Address: __________________________________________________________________________________________
Was parent/guardian or other individual notified? Yes _____ No ____ Who: __________________________________________________________________________________________
Relationship to Student: __________________________________________________________________________________________
How Notified: __________________________________________________________________________________________ Date ___________ Time: ___________ AM ___PM ___

FOLLOW-UP
If head injury student must be seen by a Dr. and have Dr.’s release to return to school and activities.

Principal’s Signature __________________________________________________________________________________________
Signature of Person Observing or Reporting Accident __________________________________________________________________________________________
Print Name __________________________________________________________________________________________

Send completed original copy the Nurse.
CC: School File, AD, DO