



# STUDENT ACCIDENT REPORT FORM

TO BE USED FOR ALL ACCIDENTS

PERSON COMPLETING FORM \_\_\_\_\_

NAME \_\_\_\_\_ HOME ADDRESS \_\_\_\_\_ TIME OF ACCIDENT \_\_\_\_\_  
 SCHOOL \_\_\_\_\_ GENDER  M  F AGE \_\_\_\_\_ GRADE \_\_\_\_\_ DATE \_\_\_\_\_

POSITION OF PERSON INVOLVED:  STUDENT  S/D EMPLOYEE  VISITOR  OTHER \_\_\_\_\_

NATURE OF INJURY <small>(CHECK ALL THAT APPLY)</small>	BODY PART INJURED R L	LOCATION	SPECIFY SCHOOL ACTIVITY
ACCIDENTAL <input type="checkbox"/>	ANKLE <input type="checkbox"/> <input type="checkbox"/>	AUDITORIUM <input type="checkbox"/>	_____
ACCIDENTAL CONTACT <input type="checkbox"/>	ARM <input type="checkbox"/> <input type="checkbox"/>	BUS/BUS STOP <input type="checkbox"/>	_____
ANIMAL BITE/STING <input type="checkbox"/>	BACK <input type="checkbox"/> <input type="checkbox"/>	CAFETERIA <input type="checkbox"/>	_____
ASSAULT <input type="checkbox"/>	EAR <input type="checkbox"/> <input type="checkbox"/>	CLASSROOM <input type="checkbox"/>	_____
ASSAULT W/ WEAPON <input type="checkbox"/>	ELBOW <input type="checkbox"/> <input type="checkbox"/>	GYMNASIUM <input type="checkbox"/>	_____
ATHLETIC INJURY (AFTER SCHOOL) <input type="checkbox"/>	EYE <input type="checkbox"/> <input type="checkbox"/>	HALLWAY <input type="checkbox"/>	_____
ATHLETIC INJURY (DURING SCHOOL) <input type="checkbox"/>	FACE <input type="checkbox"/> <input type="checkbox"/>	LIBRARY <input type="checkbox"/>	_____
BIO-HAZARD EXPOSURE <input type="checkbox"/>	FINGER <input type="checkbox"/> <input type="checkbox"/>	LOCKER ROOM <input type="checkbox"/>	IF ACCIDENT WAS THE RESULT OF A MACHINE OR EQUIPMENT FAILURE SPECIFY THE FAILURE IN DETAIL
BURN/SCALD <input type="checkbox"/>	FOOT <input type="checkbox"/> <input type="checkbox"/>	OFF CAMPUS <input type="checkbox"/>	
CHEMICAL EXPOSURE <input type="checkbox"/>	HAND <input type="checkbox"/> <input type="checkbox"/>	PARKING LOT <input type="checkbox"/>	_____
CHIPPED TOOTH <input type="checkbox"/>	HEAD <input type="checkbox"/> <input type="checkbox"/>	PLAYGROUND <input type="checkbox"/>	_____
CHOKING <input type="checkbox"/>	HIP <input type="checkbox"/> <input type="checkbox"/>	RESTROOM <input type="checkbox"/>	_____
ELECTRICAL INJURY <input type="checkbox"/>	KNEE <input type="checkbox"/> <input type="checkbox"/>	SCHOOL GROUNDS <input type="checkbox"/>	_____
EYE INJURY <input type="checkbox"/>	LEG <input type="checkbox"/> <input type="checkbox"/>	_____ SHOP <input type="checkbox"/>	_____
FALL FROM ELEVATED SURFACE <input type="checkbox"/>	MOUTH <input type="checkbox"/> <input type="checkbox"/>	_____ FIELD <input type="checkbox"/>	_____
FRACTURE <input type="checkbox"/>	NOSE <input type="checkbox"/> <input type="checkbox"/>	OTHER _____	DOES THE STUDENT CARRY SCHOOL ACCIDENT INSURANCE <input type="checkbox"/> YES <input type="checkbox"/> NO
HIT BY FOREIGN OBJECT <input type="checkbox"/>	WRIST <input type="checkbox"/> <input type="checkbox"/>		NUMBER OF DAYS MISSED FROM SCHOOL _____
HORSEPLAY <input type="checkbox"/>	OTHER _____		
HUMAN BITE <input type="checkbox"/>			
ILLNESS <input type="checkbox"/>			
LACERATION <input type="checkbox"/>			
MEDICAL CONDITION <input type="checkbox"/>			
PUNCTURE WOUND <input type="checkbox"/>			
SMASHED <input type="checkbox"/>			
STRUCK STATIONARY OBJECT <input type="checkbox"/>			
TRIP/SLIP <input type="checkbox"/>			
VOCATIONAL <input type="checkbox"/>			

NAME OF SUPERVISOR IN CHARGE WHEN ACCIDENT OCCURRED \_\_\_\_\_

PHONE NUMBER \_\_\_\_\_

WAS SUPERVISOR PRESENT AT TIME OF ACCIDENT?  YES  NO

ACTION TAKEN	BY WHOM	SPECIFY ACTION TAKEN
FIRST AID TREATMENT <input type="checkbox"/>	_____	_____
SENT TO SCHOOL NURSE <input type="checkbox"/>	_____	_____
AMBULANCE CALLED <input type="checkbox"/>	_____	_____
SENT TO HOSPITAL <input type="checkbox"/>	_____	_____
NO TREATMENT <input type="checkbox"/>	_____	_____
CALLED PARENT/GUARDIAN <input type="checkbox"/>	_____	_____
SENT HOME <input type="checkbox"/>	_____	_____
OTHER _____ <input type="checkbox"/>	_____	_____

### WITNESSES

NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

### DESCRIPTION OF ACCIDENT

USE REVERSE SIDE IF NECESSARY

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Principal's Signature \_\_\_\_\_ Date \_\_\_\_\_

Superintendent's Signature or Designee \_\_\_\_\_ Date \_\_\_\_\_