

NOTE: SERIOUS INJURIES SHOULD BE REPORTED IMMEDIATELY BY TELEPHONE. The school employee witnessing the accident or supervising at the time should complete and submit this form to the Risk Management Office within 24 hours. Please type or print using ball point pen.

1. NAME OF INJURED _____ <small>PLEASE PRINT LAST NAME FIRST NAME</small>		HOME ADDRESS _____ HOME TELEPHONE _____	
2. SCHOOL _____ <small>PLEASE PRINT NAME</small>		SEX <input type="checkbox"/> M <input type="checkbox"/> F	AGE _____ GRADE OR CLASS _____
3. DATE OF ACCIDENT _____		TIME ACCIDENT OCCURRED: HOUR _____	
LOCATION	4. CHECK APPROPRIATE BOX(ES)		PART OF BODY INJURED
	5. CHECK APPROPRIATE BOX(ES)		
ATHLETIC FIELD <input type="checkbox"/> LOCKER RM. <input type="checkbox"/> CAFETERIA <input type="checkbox"/> PLAYGROUND <input type="checkbox"/> CLASSROOM <input type="checkbox"/> POOL <input type="checkbox"/> CORRIDOR <input type="checkbox"/> SCIENCE LAB <input type="checkbox"/> GYM <input type="checkbox"/> SHOP LAB <input type="checkbox"/> LAVATORY <input type="checkbox"/> SHOWER <input type="checkbox"/> OTHER (SPECIFY) _____ STAIRS <input type="checkbox"/>		ABRASION <input type="checkbox"/> PUNCTURE <input type="checkbox"/> BITE <input type="checkbox"/> SPRAIN <input type="checkbox"/> BRUISE <input type="checkbox"/> SWELLING <input type="checkbox"/> CUT <input type="checkbox"/> TOOTH-CHIPPED <input type="checkbox"/> DISLOCATION <input type="checkbox"/> TOOTH-LOOSENED <input type="checkbox"/> FRACTURE <input type="checkbox"/> TOOTH-LOST <input type="checkbox"/> INTERNAL <input type="checkbox"/> NO VISIBLE INJURY <input type="checkbox"/> OTHER (SPECIFY) _____	
DESCRIPTION OF THE ACCIDENT	7. HOW DID ACCIDENT HAPPEN? WHAT WAS STUDENT DOING? WHERE WAS STUDENT? LIST UNSAFE ACTS AND UNSAFE CONDITIONS EXISTENT. SPECIFY ANY TOOL, MACHINE, OR EQUIPMENT INVOLVED.		TYPE OF PLAYGROUND EQUIPMENT
	_____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____		
8. TEACHER IN CHARGE WHEN ACCIDENT OCCURRED (ENTER NAME)		PRESENT AT SCENE OF ACCIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO	
LAST _____		FIRST _____ INITIAL _____	
IMMEDIATE ACTION TAKEN	10. FIRST AID TREATMENT _____ BY (NAME) _____		
	SENT HOME _____ BY (NAME) _____		
	SENT TO HOSPITAL _____ BY (NAME) _____		
	NAME OF HOSPITAL _____		
	SENT TO SCHOOL NURSE _____ BY (NAME) _____		
SENT TO PHYSICIAN _____ BY (NAME) _____			
PHYSICIAN'S NAME _____			
11. WAS PARENT OR OTHER INDIVIDUAL NOTIFIED? <input type="checkbox"/> YES <input type="checkbox"/> NO WHEN _____ HOW _____			
NAME OF INDIVIDUAL NOTIFIED _____			
12. WITNESS 1. (NAME) _____		2. (NAME) _____	
ADDRESS _____		ADDRESS _____	
SIGNED TEACHER _____		PRINCIPAL _____	
		DATE _____	