

**LUMPKIN COUNTY BOARD OF EDUCATION
FIRST REPORT OF ACCIDENT/INCIDENT**

Injured Person Information: (Circle One) **Employee** or **Student** or **Visitor**

Name _____ Birthdate _____ Sex: ___ Male or ___ Female

Address _____
City _____ State _____ Zip Code _____

Phone # _____ Cell # _____ Date of Accident _____
(MM/DD/YY)

Facility (circle one): **BES LBES LCES LCMS LCHS OTHER** _____ Time of Accident _____
(Hr Min AM or PM)

| <u>Location</u> | <u>Type of Injury</u> | <u>Body Part Injured</u> | | | |
|-------------------------|------------------------|--------------------------|-----------|---|---|
| Athletic Field | Abrasion | Abdomen | | | |
| Auditorium | Bite | Ankle | R | L | B |
| Bathroom | Blisters | Arm | R | L | B |
| Cafeteria | Bruise | Chest | | | |
| Classroom | Burn | Ear | R | L | B |
| Commons Area | Cut/ Laceration | Elbow | R | L | B |
| Corridor | Poisoning | Eye | R | L | B |
| Labs | Puncture | Finger(s) | R, L or B | | |
| Parking Area | Scratch | Foot | R | L | B |
| Playground | Sprain | Hand | R | L | B |
| Showers | Tooth Damage | Head | | | |
| Stairs | Other _____ | Hip | R | L | B |
| Work Shop | | Knee | R | L | B |
| Other _____ | | Leg | R | L | B |
| | <u>Possible Injury</u> | Mouth | | | |
| <u>Degree of Injury</u> | Concussion | Neck | | | |
| Non-disabling | Dislocation | Shoulder | R | L | B |
| Temporary | Fracture or Break | Teeth | | | |
| Permanent disability | Internal Injury | Toe(s) | R, L or B | | |
| Death | Strain or Sprain | Wrist | R | L | B |
| | | Other | | | |

Describe how injury or illness/health condition occurred (include cause): _____

(Continue on back of page as needed)

Witness(es), if any: _____
(Witness should describe how he/she saw the accident or injury occur on the back of this form)

Initial Treatment Given (circle one): **None** or **Minor by Nurse** or **Minor by Clinic/Dr** or **ER** or **Hospital**

If applicable, Clinic/Dr _____ or Hospital _____

If Student: Parents Notified? Yes or No Released to: Parent or EMS/Hospital or Back to Class

If Employee: Supervisor Notified on _____ First Day Failed to Work _____
Did employee return to work? Yes or No If No: Date returned to work _____
Employee's signature _____ Date _____

Supervisor/Principal Signature _____

Date _____

Report Completed By _____

SEND COMPLETED REPORT TO DIANA JOHNSON OR MARY WHITE AT THE CENTRAL OFFICE

Body Diagram (Anterior/Posterior)

Right

Left

Left

Right

