



STUDENT ACCIDENT REPORT

Student Name: _____ School: _____
 Date of Birth: _____ Age: _____ Grade: _____ Home Phone: (____) _____
 Home Address: _____ Student is covered by Insurance? Yes No
 City, Zip: _____ Name of Insurance: _____

<i>Site Name</i>	Date & Time of Injury: _____ / ____:____ am / pm
<i>Location Details (i.e. Athletic Field, Gym, Off Campus, etc.)</i>	<i>Type of sports/recreation activity:</i>
<i>List equipment involved in injury:</i>	Was there a violation of a school rule by this student or anyone else? <input type="checkbox"/> Yes <input type="checkbox"/> No Was the accident due to faulty apparatus or material? <input type="checkbox"/> Yes <input type="checkbox"/> No Did this injury result from violence or aggression? <input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Who else was involved in the accident/injury:</i> <input type="checkbox"/> Another Student <input type="checkbox"/> Outside Person <input type="checkbox"/> Unknown <input type="checkbox"/> No One	<i>Name of Supervising Employee in Charge:</i>
<i>Cause of the injury (circle all appropriate selections below):</i> Animal/Insect Building Classroom Materials Food/Drink Hand Tool Power Tool Sport Equipment Thrown Object Another Student Chemicals Fence/Gate Furniture Pole Self Surface Vehicle <i>Other (specify):</i> _____	
<i>Nature of the injury (circle all appropriate selections below):</i> Abrasion Bruise Chipped/Lose Tooth Dislocation Fracture No Visible Injury Redness Bite/Sting Burn Concussion Dizziness Internal Pain Sprain/Strain Bleeding Chemical Exposure Cut Foreign Body Nausea Puncture Swelling <i>Other (specify):</i> _____	
<i>What part(s) of the body was injured (circle all appropriate selections below)?</i> Ankle Back Ear Eye Finger Groin Head Internal Leg Neck Ribs Stomach Wrist Arm Chest Elbow Face Foot Hand Hip Knee Mouth Nose Shoulder Tooth <i>Other (specify):</i> _____	
<i>Side of body (check box):</i> <input type="checkbox"/> Left <input type="checkbox"/> Right	
<i>Briefly describe how the injury occurred:</i> _____ _____ _____	
Was First Aid administered? <input type="checkbox"/> Yes <input type="checkbox"/> No Describe First Aid given: _____ By whom: _____	
<i>Witness Names and Phone Numbers:</i> _____ <i>Statements were collected from the following witnesses (please check box as appropriate):</i> <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	
Report completed by: _____ Phone: _____ Title: _____ Date: _____	
Student was: <input type="checkbox"/> Returned to Class <input type="checkbox"/> Sent Home <input type="checkbox"/> Taken to the Hospital <input type="checkbox"/> Other: _____ Comments: _____	
Were the Parents/Guardians Contacted? <input type="checkbox"/> Yes <input type="checkbox"/> No Describe their reactions/comments: _____ _____ _____	