



## STUDENT ACCIDENT REPORT

Student Name: \_\_\_\_\_ Date & Time of Injury: \_\_\_\_\_ / \_\_\_\_:\_\_\_\_ am / pm  
 Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_  
 Home Address: \_\_\_\_\_ Student is covered by Insurance?  Yes  No  
 Name of Insurance: \_\_\_\_\_

<i>Location (i.e. Athletic Field, Gym, Off Campus, Classroom, 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"/> _____ <input type="checkbox"/> _____	
<i>Report completed by:</i> _____ _____ <i>Title</i> _____	_____ _____ <i>Phone</i> _____ _____ <i>Date</i> _____
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: _____ _____	