

Accident Report

This form is to be completed by the appropriate employee(s) as soon as possible after an accident occurs. Please Print or Type.

District Name _____ School Name _____
 Principal's Name _____ School Phone _____
 Date of Accident: _____ Time: ____ AM PM Supervising Employee _____

Claimant's Name _____
Last Name *First Name* *Middle Initial*
 Claimant's Address _____
City *State* *ZIP Code*
 Claimant's SS # _____ Home Phone Number (____) _____
 Claimant's Age _____ Date of Birth _____ Sex _____ Grade _____
 Parent's Name (if student) _____ Work Phone Number (____) _____

<i>Nature of Injury</i>	
<input type="checkbox"/> Scratch	<input type="checkbox"/> Concussion
<input type="checkbox"/> Fracture	<input type="checkbox"/> Head Injury
<input type="checkbox"/> Bruise	<input type="checkbox"/> Sprain/Strain
<input type="checkbox"/> Burn	<input type="checkbox"/> Cut/Puncture
<input type="checkbox"/> Dislocation	<input type="checkbox"/> Bite
<input type="checkbox"/> Other _____	

<i>Place of Accident</i>	
<input type="checkbox"/> Classroom	<input type="checkbox"/> Gymnasium
<input type="checkbox"/> Hallway	<input type="checkbox"/> Parking Lot
<input type="checkbox"/> Bathroom	<input type="checkbox"/> Sidewalk
<input type="checkbox"/> Cafeteria	<input type="checkbox"/> Stairs
<input type="checkbox"/> Playground	<input type="checkbox"/> Athletic Field
<input type="checkbox"/> Other _____	

<i>Body Part Injured</i>		
<input type="checkbox"/> Ankle	<input type="checkbox"/> Foot	<input type="checkbox"/> Leg
<input type="checkbox"/> Arm	<input type="checkbox"/> Face	<input type="checkbox"/> Nose
<input type="checkbox"/> Back	<input type="checkbox"/> Finger	<input type="checkbox"/> Teeth
<input type="checkbox"/> Neck	<input type="checkbox"/> Hand	<input type="checkbox"/> Wrist
<input type="checkbox"/> Eye	<input type="checkbox"/> Knee	<input type="checkbox"/> Shoulder
<input type="checkbox"/> Other _____		

Describe accident and injury in detail (attach additional description as necessary): _____

Were efforts made to contact the parent/guardian about the accident? Yes No
 Was first aid administered? Yes No By whom? _____
 Was the student Sent home Sent to physician Sent to hospital
 Is student covered by Student Accident Insurance? Yes No If "yes," please list Company Name, address, and phone number _____

If medical or hospital treatment was required, please complete the following information. (Attach a copy of medical bills, if available.)

Name and address of doctor or hospital _____
 Witnesses (Name, Address, and Phone) _____

Signature/Name of Person Completing the Report *Date*