Clarkston SCHOOL DISTRICT
Honor the Past. Be the Future.

# INCIDENT REPORT FORM

PERSON COMPLETING FORM

**NAME:** **HOME ADDRESS:**

**SCHOOL:** **GENDER: M F** **AGE:** **GRADE:** **DATE:**

**DATE OF ACCIDENT:** **TIME OF ACCIDENT:**

**POSITION OF PERSON INVOLVED (STAFF, STUDENT, VISITOR, OTHER):**

| NATURE OF INJURY (CHECK ALL THAT APPLY) | | BODY PART INJURED | R | L | LOCATION | | SPECIFY SCHOOL ACTIVITY |
|---|---|---|---|---|---|---|---|
| ACCIDENTAL | | ANKLE | | | AUDITORIUM | | ACTIVITY: |
| ACCIDENTAL CONTACT | | ARM | | | BUS/BUS STOP | | |
| ANIMAL BITE/STING | | BACK | | | CAFETERIA | | |
| ASSAULT (CIRCLE): VERBAL/PHYSICAL | | EAR | | | CLASSROOM | | |
| ASSAULT W/WEAPON | | ELBOW | | | GYMNASIUM | | IF ACCIDENT WAS THE RESULT OF A |
| ATHLETIC INJURY (AFTER SCHOOL) | | EYE | | | HALLWAY | | MACHINE OR EQUIPMENT FAILURE, SPECIFY |
| ATHLETIC INJURY (DURING SCHOOL) | | FACE | | | LIBRARY | | THE FAILURE IN DETAIL: |
| BIO-HAZARD EXPOSURE | | FINGER | | | LOCKER | | |
| BURN/SCALD | | FOOT | | | OFF CAMPUS | | |
| CHEMICAL EXPOSURE | | HAND | | | LOCATION: | | |
| CHIPPED TOOTH | | HEAD | | | PARKING LOT | | |
| CHOKING | | HIP | | | PLAYGROUND | | |
| ELECTRICAL INJURY | | KNEE | | | RESTROOM | | |
| EYE INJURY | | LEG | | | SCHOOL GROUNDS | | NUMBER OF DAYS MISSED FROM |
| FALL FROM ELEVATED SURFACE | | MOUTH | | | LOCATION: | | SCHOOL: |
| FRACTURE | | NOSE | | | SHOP | | Dates: |
| HIT BY FOREIGN OBJECT | | WRIST | | | FIELD | | |
| HIT/STRUCK BY STUDENT | | OTHER: | | | OTHER: | | |
| HORSEPLAY | | EMOTIONAL IMPACT (CIRCLE) : LOW MEDIUM HIGH | | | | | |
| HUMAN BITE | | VERBAL ABUSE (IMPACT/WORDS): | | | | | |
| ILLNESS | | | | | | | |
| LACERATION | | SUPERVISOR IN CHARGE WHEN ACCIDENT OCCURRED: | | | | | |
| MEDICAL CONDITION | | PHONE NUMBER: | | | | | |
| PUNCTURE WOUND | | WAS SUPERVISOR PRESENT AT TIME OF ACCIDENT? Y N | | | | | |
| SPITTING | | NUMBER OF INCIDENTS FOR THIS STUDENT: 1 2 3 4 5 MORE THAN 5 | | | | | |
| SMASHED | | LIST WITNESSES (NAME, ADDRESS, PHONE) : | | | | | |
| STRUCK STATIONARY OBJECT | | | | | | | |
| TRIP/SLIP | | | | | | | |
| VOCATIONAL | | | | | | | |

| ACTION TAKEN | | BY WHOM | SPECIFY ACTION TAKEN |
|---|---|---|---|
| FIRST AID TREATMENT | | | |
| SENT TO SCHOOL NURSE | | | |
| AMBULANCE CALLED | | | |
| SENT TO HOSPITAL | | | |
| NO TREATMENT | | | |
| CALLED PARENT/GUARDIAN | | | |
| OTHER: | | | |

*Send completed form to District Office*

In completing this accident report, it is essential that the accident be described in sufficient detail to show conditions existing when the accident occurred. If unsafe acts or conditions are noted, steps should be taken immediately for their correction.

**DESCRIPTION OF ACCIDENT**

Principal or Designee Signature

Date

Health Services Staff Signature

Date

*Send completed form to District Office*