



ACCIDENT REPORT FORM

PERSON COMPLETING FORM _____

NAME _____ HOME ADDRESS _____

SCHOOL _____ GENDER M F AGE _____ GRADE _____ DATE _____

DATE OF ACCIDENT _____ TIME OF ACCIDENT _____ AM PM

POSITION OF PERSON INVOLVED: STUDENT VISITOR OTHER _____

NATURE OF INJURY (CHECK ALL THAT APPLY)	BODY PART INJURED		LOCATION	SPECIFY SCHOOL ACTIVITY
	R	L		
ACCIDENTAL <input type="checkbox"/>	ANKLE <input type="checkbox"/>	<input type="checkbox"/>	AUDITORIUM <input type="checkbox"/>	
ACCIDENTAL CONTACT <input type="checkbox"/>	ARM <input type="checkbox"/>	<input type="checkbox"/>	BUS/BUS STOP <input type="checkbox"/>	
ANIMAL BITE/STING <input type="checkbox"/>	BACK <input type="checkbox"/>	<input type="checkbox"/>	CAFETERIA <input type="checkbox"/>	
ASSAULT <input type="checkbox"/>	EAR <input type="checkbox"/>	<input type="checkbox"/>	CLASSROOM <input type="checkbox"/>	
ASSAULT W/WEAPON <input type="checkbox"/>	ELBOW <input type="checkbox"/>	<input type="checkbox"/>	GYMNASIUM <input type="checkbox"/>	IF ACCIDENT WAS THE RESULT OF A MACHINE OR EQUIPMENT FAILURE, SPECIFY THE FAILURE IN DETAIL
ATHLETIC INJURY (AFTER SCHOOL) <input type="checkbox"/>	EYE <input type="checkbox"/>	<input type="checkbox"/>	HALLWAY <input type="checkbox"/>	
ATHLETIC INJURY (DURING SCHOOL) <input type="checkbox"/>	FACE <input type="checkbox"/>	<input type="checkbox"/>	LIBRARY <input type="checkbox"/>	
BIO-HAZARD EXPOSURE <input type="checkbox"/>	FINGER <input type="checkbox"/>	<input type="checkbox"/>	LOCKER ROOM <input type="checkbox"/>	
BURN/SCALD <input type="checkbox"/>	FOOT <input type="checkbox"/>	<input type="checkbox"/>	OFF CAMPUS <input type="checkbox"/>	
CHEMICAL EXPOSURE <input type="checkbox"/>	HAND <input type="checkbox"/>	<input type="checkbox"/>	(LOCATION):	
CHIPPED TOOTH <input type="checkbox"/>	HEAD <input type="checkbox"/>	<input type="checkbox"/>	PARKING LOT <input type="checkbox"/>	
CHOKING <input type="checkbox"/>	HIP <input type="checkbox"/>	<input type="checkbox"/>	PLAYGROUND <input type="checkbox"/>	
ELECTRICAL INJURY <input type="checkbox"/>	KNEE <input type="checkbox"/>	<input type="checkbox"/>	RESTROOM <input type="checkbox"/>	DOES THIS STUDENT CARRY SCHOOL ACCIDENT INSURANCE <input type="checkbox"/> YES <input type="checkbox"/> NO
EYE INJURY <input type="checkbox"/>	LEG <input type="checkbox"/>	<input type="checkbox"/>	SCHOOL GROUNDS <input type="checkbox"/>	
FALL FROM ELEVATED SURFACE <input type="checkbox"/>	MOUTH <input type="checkbox"/>	<input type="checkbox"/>	(LOCATION):	
FRACTURE <input type="checkbox"/>	NOSE <input type="checkbox"/>	<input type="checkbox"/>	SHOP: <input type="checkbox"/>	NUMBER OF DAYS MISSED FROM SCHOOL _____
HIT BY FOREIGN OBJECT <input type="checkbox"/>	WRIST <input type="checkbox"/>	<input type="checkbox"/>	FIELD: <input type="checkbox"/>	
HORSEPLAY <input type="checkbox"/>	OTHER: <input type="checkbox"/>		OTHER: <input type="checkbox"/>	
HUMAN BITE <input type="checkbox"/>				
ILLNESS <input type="checkbox"/>	NAME OF SUPERVISOR IN CHARGE WHEN ACCIDENT OCCURRED: _____			
LACERATION <input type="checkbox"/>				
MEDICAL CONDITION <input type="checkbox"/>	PHONE NUMBER _____			
PUNCTURE WOUND <input type="checkbox"/>				
SMASHED <input type="checkbox"/>				
STRUCK STATIONARY OBJECT <input type="checkbox"/>				
TRIP/SLIP <input type="checkbox"/>	WAS SUPERVISOR PRESENT AT TIME OF ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			
VOCATIONAL <input type="checkbox"/>				
ACTION TAKEN	BY WHOM		SPECIFY ACTION TAKEN	
FIRST AID TREATMENT <input type="checkbox"/>				
SENT TO SCHOOL NURSE <input type="checkbox"/>				
AMBULANCE CALLED <input type="checkbox"/>				
SENT TO HOSPITAL <input type="checkbox"/>				
NO TREATMENT <input type="checkbox"/>				
CALLED PARENT/GUARDIAN <input type="checkbox"/>				
SENT HOME <input type="checkbox"/>				
OTHER: <input type="checkbox"/>				

WITNESSES

NAME: _____ ADDRESS: _____ PHONE: _____

NAME: _____ ADDRESS: _____ PHONE: _____

***DESCRIPTION OF ACCIDENT**
USE REVERSE SIDE IF NECESSARY
