ACCIDENT RESPONSE AND PREVENTION
(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

Accident Information

District _____ Principal _____

School _____ School Phone _____

Date of Accident _____ Time _____ □ AM □ PM Supervising employee _____

Accident victim's name _____

Accident victim's address _____

Home phone _____ Date of birth _____ Sex □ M □ F Grade _____

Parent/Guardian(s) _____

Home phone _____ Work phone _____

Nature of Injury	
□ Scratch	□ Concussion
□ Fracture	□ Head Injury
□ Bruise	□ Sprain/Strain
□ Burn	□ Cut/Puncture
□ Dislocation	□ Bite
□ Other _____	

Place of Accident	
□ Classroom	□ Gymnasium
□ Hallway	□ Parking Lot
□ Restroom	□ Sidewalk
□ Cafeteria	□ Stairs
□ Playground	□ Athletic Field
□ Other _____	

Body Part Injured		
□ Ankle	□ Foot	□ Leg
□ Arm	□ Face	□ Nose
□ Back	□ Finger	□ Teeth
□ Neck	□ Hand	□ Wrist
□ Eye	□ Knee	□ Shoulder
□ Other _____		

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

_____

_____

_____

Were efforts made to contact the parent/guardian about the accident? □ Yes □ No

Was contact made? □ Yes □ No If yes, with whom? _____

Was first aid administered? □ Yes □ No If yes, by whom?_____

The student was □ Sent home □ Sent to physician □ Sent to hospital

Student was transported by _____

Is student covered under Student Accident Insurance? □ Yes □ No □ Unknown

If yes, please list company name, address, and phone number _____

_____

If medical or hospital treatment was required, please complete the following information.

Name/Address of doctor or hospital:

_____

_____

_____

Name, address and phone of witness:

_____

_____

_____

_____ _____

Signature of Person Completing Report Date