ACCIDENT/INCIDENT REPORT FORM

Date of incident: Time:

Name of injured person:

Address:

Phone Number(s):

Date of birth: _____ Male _____ Female _____

Who was injured person?(select one) School Employee Student District Patron Visitor

Type of injury:

Details of incident:

Injury requires physician/hospital visit? Yes ___ No _____ Unsure _____

If No, please provide explanation:

Name of physician/hospital:

Address:

Physician/hospital phone number:

Signature of injured party

_____

Date

_____

Signature of Grand View School representative familiar with the accident/incident. Date

Return this form to Superintendent.