

**Abingdon-Avon CUSD #276
Injury / Accident Report Form
Information for STUDENT injuries**

Student Vendor Visitor/Customer Date: _____

Injured Party: _____ Address: _____ Phone: _____

Sex: M F Age: _____ Date of Accident: _____

Time of accident: _____ AM PM Place of Accident: _____

Location of Accident: _____

*(If injured is an employee, a Form 45 must still be completed.)

Cause of Injury

Bodily Reaction <input type="checkbox"/>	Lifting <input type="checkbox"/>
Caught In <input type="checkbox"/>	Overexertion <input type="checkbox"/>
Chemical Contact <input type="checkbox"/>	Rep Motion <input type="checkbox"/>
Exposure <input type="checkbox"/>	Fall (elevation) <input type="checkbox"/>
Struck by <input type="checkbox"/>	Slip/trip/fall <input type="checkbox"/>
Struck on <input type="checkbox"/>	Heat Contact <input type="checkbox"/>
Other: _____	

Description of the Injury

How did the injury happen? _____

What was injured person doing? _____

List specifically unsafe acts or conditions. _____

Specify any tool, machine, or equipment involved. _____

Type of Injury

Bee sting <input type="checkbox"/>	Fracture <input type="checkbox"/>
Bite <input type="checkbox"/>	Hernia <input type="checkbox"/>
Burn (chem) <input type="checkbox"/>	Laceration <input type="checkbox"/>
Burn (heat) <input type="checkbox"/>	Multiple <input type="checkbox"/>
Chemical <input type="checkbox"/>	Occptnl Illness <input type="checkbox"/>
Contusion <input type="checkbox"/>	Puncture <input type="checkbox"/>
Crush <input type="checkbox"/>	Rash <input type="checkbox"/>
Cum Trauma <input type="checkbox"/>	Sprain (ligmt) <input type="checkbox"/>
Death <input type="checkbox"/>	Strain (musc) <input type="checkbox"/>
Foreign Object <input type="checkbox"/>	Stress <input type="checkbox"/>
Other: _____	

Part of Body

Arm <input type="checkbox"/>	Back <input type="checkbox"/>	Eye <input type="checkbox"/>	Foot <input type="checkbox"/>	Ankle <input type="checkbox"/>	Mental <input type="checkbox"/>	Torso/Trunk <input type="checkbox"/>
Groin <input type="checkbox"/>	Head/Face <input type="checkbox"/>	Internal <input type="checkbox"/>	Knee <input type="checkbox"/>	Leg <input type="checkbox"/>	Respiratory <input type="checkbox"/>	Wrist/hand <input type="checkbox"/>
Other: _____						

Immediate Action Taken

First-aid treatment By (Name): _____

Sent to physician By (Name): _____
 Physician's Name: _____

Sent to hospital By (Name): _____
 Name of Hospital: _____

Witnesses

1. Name: _____ Addresses: _____ Phone: _____

2. Name: _____ Addresses: _____ Phone: _____

What suggestion do you have for preventing other accidents of this type?

Signatures

School Employee: _____ Date: _____

Submit to District Office (within 24 hours)