ACCIDENT/ILLNESS REPORT

This form should be completed on any occurrence which results in injury or illness.

PERSONAL DATA

Name of Person Injured _____ Date of Birth ____/____/____ (MO./DAY/YR.) ☐ Male ☐ Female

Name of School Attends/Employed _____ Grade Level/Dept. _____

Parent/Guardian Name(s) _____

Home Address _____ (STREET) (CITY) (STATE) (ZIP)

Home Phone _____ Business Phone _____ Parents Contacted ☐ Yes ☐ No

ACCIDENT DESCRIPTION

Date of Accident ____/____/____ (MO./DAY/YR.) Time of Accident _____ ☐ AM ☐ PM Date Reported ____/____/____ (MO./DAY/YR.)

Location of Accident ☐ Classroom ☐ Gymnasium ☐ Cafeteria ☐ Hallway ☐ School Grounds ☐ Other _____

Give a Detailed Description of Accident _____

_____

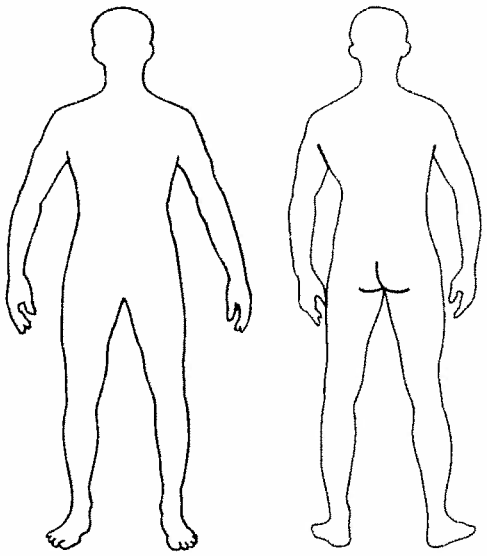
_____

_____

_____ SIGNATURE OF SUPERVISOR/TEACHER

PARTS OF BODY INJURED

HEAD/NECK	UPPER EXTREMITIES	LOWER EXTREMITIES	TRUNK
☐ Skull	☐ Shoulder(s) R L	☐ Hip(s) R L	☐ Upper back
☐ Face	☐ Upper arm(s) R L	☐ Thigh(s) R L	☐ Lower back
☐ Neck	☐ Elbow(s) R L	☐ Knee(s) R L	☐ Collarbone
☐ Ear(s) R L	☐ Forearm(s) R L	☐ Lower leg(s) R L	☐ Chest
☐ Eye(s) R L	☐ Wrist(s) R L	☐ Ankle(s) R L	☐ Lung(s)
☐ Nose	☐ Hand(s) R L	☐ Foot R L	☐ Ribs
☐ Teeth	☐ Finger(s) R L	☐ Toe(s) R L	☐ Pelvis
☐ Mouth	_____	_____	☐ Internal



MARK INJURED AREAS OF BODY

SPECIFIC TYPE OF INJURY

☐ Amputation	☐ Concussion	☐ Inflammation	☐ Puncture
☐ Asphyxiation	☐ Cut/Laceration/Abrasion	☐ Ligaments/Cartilage	☐ Shock (electrical)
☐ Bite	☐ Dislocation	☐ Overheated	☐ Spraln/Strain
☐ Bruise/Contusion	☐ Fracture	☐ Paralysis	☐ Sting
☐ Burn/Scald	☐ Frostbite	☐ Poisoning (solid, liquid, gas, vapor)	☐ Teeth injury
☐ Chest Pains	☐ Hearing Loss		☐ Vision loss

☐ Other (specify) _____

MEDICAL ATTENTION

☐ First aid administered. Describe first aid given _____

_____ _____ SIGNATURE OF PERSON ADMINISTERING FIRST AID

☐ Taken to school nurse ☐ Taken to doctor/clinic ☐ Taken home, by whom _____ ☐ Returned to normal activity

☐ Ambulance called ☐ Taken to hospital, by whom _____ ☐ ADMITTED ☐ RELEASED

_____ OF HOSPITAL/DOCTOR _____ ADDRESS OF HOSPITAL/DOCTOR

Witness(es) to Accident _____ NAME ADDRESS PHONE

_____ NAME ADDRESS PHONE

Final Results _____ Signature _____ NAME OF PERSON FILING REPORT DATE