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.

District Name: _____ School Name: _____

Principal's Name: _____ School Phone: _____

Date of Accident: _____ Time: _____ Supervising Employee: _____

Claimant's Name: _____
Last Name *First Name* *Middle Initial*

Claimant's Address: _____
Street or P.O. Box *City* *State* *ZIP Code*

Claimant's SS#: _____ Home Phone No: _____

Claimant's Age: _____ Birthdate: _____ Sex: _____ Grade: _____

Parent's Name (if student): _____ Work Phone No: _____

Nature of Injury				Accident Location				Body Part Injured			
Scratch	☐	Concussion	☐	Classroom	☐	Gymnasium	☐	Ankle	☐	Foot	☐	Leg	☐
Fracture	☐	Head Injury	☐	Hallway	☐	Parking Lot	☐	Arm	☐	Face	☐	Nose	☐
Bruise	☐	Sprain/Strain	☐	Bathroom	☐	Sidewalk	☐	Back	☐	Finger	☐	Teeth	☐
Burn	☐	Cut/Puncture	☐	Cafeteria	☐	Stairs	☐	Neck	☐	Hand	☐	Wrist	☐
Dislocation	☐	Bite	☐	Playground	☐	Athletic Field	☐	Eye	☐	Knee	☐	Shoulder	☐
Other:				Other:				Other:					

Describe accident and injury in detail (attach additional description as necessary):

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

Was first aid administered? ☐ Yes ☐ No

By Whom? _____

Was the student ☐ Sent home ☐ Sent to physician ☐ Sent to hospital

Is student covered by Student Accident Insurance? ☐ Yes ☐ No

If yes, please list Company Name, address and phone number:

If medical or hospital treatment was required, please complete the following information:
(Attach a copy of medical bills, if available)

Name and address of doctor or hospital: _____

Witnesses (name, address & phone):

_____ _____
Signature/Name of Person Completing the Report Date