ACCIDENT REPORT FORM

SCHOOL DISTRICT

TO BE USED FOR ALL ACCIDENTS

PERSON COMPLETING FORM

NAME	HOME ADDRESS		TIME OF ACCIDENT	
SCHOOL GENDER M	☐ F AGE GR	ADE DATE		
POSITION OF PERSON INVOLVED: ☐ STUDENT ☐ S/D EMPLOYEE ☐ VISITOR ☐ OTHER				
NATURE OF INJURY (CHECK ALL THAT APPLY)	BODY PART INJURED R L	LOCATION	SPECIFY SCHOOL ACTIVITY	
ACCIDENTAL	ANKLE	AUDITORIUM BUS/BUS STOP CAFETERIA CLASSROOM GYMNASIUM HALLWAY LIBRARY LOCKER ROOM OFF CAMPUS	IF ACCIDENT WAS THE RESU	
CHEMICAL EXPOSURE CHIPPED TOOTH CHOKING ELECTRICAL INJURY EYE INJURY FALL FROM ELEVATED SURFACE FRACTURE	HAND	PARKING LOT PLAYGROUND RESTROOM SCHOOL GROUNDS SHOP FIELD	EQUIPMENT FAILURE SPECIFY T	
HIT BY FOREIGN OBJECT HORSEPLAY HUMAN BITE	WRIST OTHER	OTHER	SCHOOL ACCIDENT INSURANCE SYES NO	NUMBER OF DAYS MISSED FROM SCHOOL
ILLNESS LACERATION MEDICAL CONDITION PUNCTURE WOUND SMASHED STRUCK STATIONARY OBJECT TRIP/SLIP VOCATIONAL	NAME OF SUPERVISOR IN CHARGE WHEN ACCIDENT OCCURRED PHONE NUMBER WAS SUPERVISOR PRESENT AT TIME OF ACCIDENT? YES NO			
ACTION TAKEN	BY WHOM		SPECIFY ACTION TAKEN	
FIRST AID TREATMENT SENT TO SCHOOL NURSE AMBULANCE CALLED SENT TO HOSPITAL NO TREATMENT CALLED PARENT/GUARDIAN SENT HOME OTHER				
WITNESSES				
NAME	ADDRE	SS	PHONE_	
NAME	ADDRESS		PHONE	
DESCRIPTION OF ACCIDENT USE REVERSE SIDE IF NECESSARY				
Superintendent's Signature Date				