Accident Report

District Name: Metcalfe

School Name

Principal's Name

School Phone #

Date of Accident

Time of Accident

Supervising Employee

Claimant Information

Last Name

First Name

Middle Initial

City

State

Zip Code

Age

Social Security #

Home Phone #

Date of Birth

Gender

Grade

Parent's Name (if applicable)

Parent's Work Phone Number

Nature of Injury

Scratch ☐ Concussion ☐ Fracture ☐ Head Injury ☐

Bruise ☐ Sprain/Strain ☐ Burn ☐ Cut/Puncture ☐

Dislocation ☐ Bite ☐ Other

Place of Accident

Classroom ☐ Gymnasium ☐ Hallway ☐ Parking Lot ☐

Bathroom ☐ Sidewalk ☐ Cafeteria ☐ Stairs ☐

Playground ☐ Athletic Field ☐ Other

Body Part Injured

Ankle ☐ Foot ☐ Leg ☐ Arm ☐

Face ☐ Nose ☐ Back ☐ Finger ☐

Teeth ☐ Neck ☐ Hand ☐ Wrist ☐

Eye ☐ Knee ☐ Shoulder ☐ Other

Describe the accident in detail:

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

If yes, please list: Company Name | Company Address | Company Phone Number

If medical or hospital treatment was required, please provide the following information

Name of Doctor or Hospital

Address of Doctor or Hospital

Witness: Name Address Phone #