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: ____ ☐ AM ☐ PM Supervising Employee _____

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

Claimant's Address _____
City *State* *ZIP Code*

Claimant's SS # _____ Home Phone Number (___) _____

Claimant's Age _____ Date of Birth _____ Sex _____ Grade _____

Parent's Name (if student) _____ 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 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 the 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*

RELATED PROCEDURE: 03.14 AP.1

Review/Revised:3/19/07