

# STUDENT ACCIDENT REPORT FORM

TO BE USED FOR ALL ACCIDENTS

Person Completing Form \_\_\_\_\_ Date \_\_\_\_\_

Name	Home Address	Phone #
School	Gender    M    F	Age
Date of Accident	Time of Accident	Birthdate
Grade		

NATURE OF INJURY (check all that apply)		BODY PART INJURED (check all that apply)	Right	Left	LOCATION		SPECIFY ACTIVITY
Accidental	<input type="checkbox"/>				Auditorium	<input type="checkbox"/>	If the accident was the result of machine or equipment failure, specify the failure in detail.
Accidental Contact	<input type="checkbox"/>	Ankle	<input type="checkbox"/>	<input type="checkbox"/>	Bus/Bus Stop	<input type="checkbox"/>	
Animal Bite/Sting	<input type="checkbox"/>	Arm	<input type="checkbox"/>	<input type="checkbox"/>	Cafeteria	<input type="checkbox"/>	
Assault	<input type="checkbox"/>	Back	<input type="checkbox"/>	<input type="checkbox"/>	Gym	<input type="checkbox"/>	
Assault w/Weapon	<input type="checkbox"/>	Ear	<input type="checkbox"/>	<input type="checkbox"/>	Hallway	<input type="checkbox"/>	
Athletic Injury (after school)	<input type="checkbox"/>	Elbow	<input type="checkbox"/>	<input type="checkbox"/>	Library	<input type="checkbox"/>	
Athletic Injury (during school)	<input type="checkbox"/>	Eye	<input type="checkbox"/>	<input type="checkbox"/>	Locker room	<input type="checkbox"/>	
Bio-Hazard Exposure	<input type="checkbox"/>	Face	<input type="checkbox"/>	<input type="checkbox"/>	Off Campus	<input type="checkbox"/>	
Burn/Scald	<input type="checkbox"/>	Finger	<input type="checkbox"/>	<input type="checkbox"/>	Parking Lot	<input type="checkbox"/>	
Chemical Exposure	<input type="checkbox"/>	Foot	<input type="checkbox"/>	<input type="checkbox"/>	Playground	<input type="checkbox"/>	
Chipped Tooth	<input type="checkbox"/>	Hand	<input type="checkbox"/>	<input type="checkbox"/>	Restroom	<input type="checkbox"/>	
Choking	<input type="checkbox"/>	Head	<input type="checkbox"/>	<input type="checkbox"/>	School Grounds	<input type="checkbox"/>	
Electrical Injury	<input type="checkbox"/>	Hip	<input type="checkbox"/>	<input type="checkbox"/>	Shop	<input type="checkbox"/>	
Eye	<input type="checkbox"/>	Knee	<input type="checkbox"/>	<input type="checkbox"/>	Field	<input type="checkbox"/>	
Fall from Elevated Surface	<input type="checkbox"/>	Leg	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	
Fracture	<input type="checkbox"/>	Mouth	<input type="checkbox"/>	<input type="checkbox"/>			
Hit by Foreign Object	<input type="checkbox"/>	Nose	<input type="checkbox"/>	<input type="checkbox"/>			
Horseplay	<input type="checkbox"/>	Wrist	<input type="checkbox"/>	<input type="checkbox"/>			
Human Bite	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>			
Illness	<input type="checkbox"/>						
Laceration	<input type="checkbox"/>	Does the student carry school accident insurance?					
Medical Condition	<input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>					
Puncture Wound	<input type="checkbox"/>	Number of days missed school					
Smashed	<input type="checkbox"/>						
Struck Stationary Object	<input type="checkbox"/>	<b>Person in charge when accident occurred</b>			<b>Present at time of accident    YES    NO</b>		
Trip/Slip	<input type="checkbox"/>	<b>Administrator's Signature</b>					
Vocational	<input type="checkbox"/>						
	<input type="checkbox"/>						
<b>ACTION TAKEN</b>	<input type="checkbox"/>	<b>BY WHOM: SPECIFY ACTION TAKEN</b>					
First Aid Treatment	<input type="checkbox"/>						
Sent to School Nurse	<input type="checkbox"/>						
Ambulance Called	<input type="checkbox"/>						
Sent to Hospital	<input type="checkbox"/>						
No Treatment	<input type="checkbox"/>						
Called Parents/Guardian	<input type="checkbox"/>						
Sent Home	<input type="checkbox"/>						
Other	<input type="checkbox"/>						

**WITNESSES: List all witnesses, use backside of sheet if necessary**

Name	Address	Phone Number
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Name	Address	Phone Number
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**DESCRIPTION OF ACCIDENT: (USE BACKSIDE OF SHEET, IF NECESSARY)**

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## PROCEDURE FOR ACCIDENT REPORTS

### **Accident Report is to be filled out:**

As a result of an accident and there is:

- Blood dispersal
- Severe and immediate bruising
- Student reports pain as a result of a significant force injury
- If first aid equipment is used (Gauze, tape, ice pack)

If head, neck, or back pain....**DON'T MOVE PATIENT**

Fill out accident report if you have any doubts, (it is better to error on the safe side)

### **If injury occurs prior to school, note it on sick room log**

Log will be kept for 8 years after the entry

### **After accident report is completed:**

Have building principal review

Original is to be kept until the student is 21 years of age or 8 years after the incident.  
These records are kept at the individual schools in a notebook, by birth year.

Send one copy to Canfield and Associates twice yearly – in January and at the end of each school year.