

# STUDENT ACCIDENT/INJURY REPORT

**A Student Accident/Injury Report is to be initiated** by staff member in charge of area where the incident occurred for:

1. Each injury resulting in one-half or more day's absence.
2. Each injury requiring a health care provider's attention.
3. Head injuries that result any of the following: loss of consciousness, nausea, vomiting, dizziness
4. **Any** accident/injury you feel warrants one

**Report to be completed within 24 hours of injury.**

Name of Student  Gender  Age  Grade

Body Part Injured  *If Applicable - Indicate left or right*

Date of Incident  Time of Incident  Building Site Where Incident Occurred:  Location of Incident within Building Site

Name of Employee Reporting Incident  Approximate number of students being supervised at the time of the incident

## Description of the Incident

Student states:

Adult witness states:

Recommendation for preventing other incidents of this type?

Please print and send through inner-office mail or submit directly by email

**Health Services will complete the remainder of the form.**

*Original to Student Health Record, Copy to Director of Business, Finance Department*

Assessment of Injury: \_\_\_\_\_

\_\_\_\_\_

Actions Taken: \_\_\_\_\_

\_\_\_\_\_

Response: \_\_\_\_\_

\_\_\_\_\_

If student seen by health care provider, identify name and clinic: \_\_\_\_\_

Signature (Nursing Staff)

Date

Signature (Principal)

Date