

STUDENT/EMPLOYEE ACCIDENT REPORT FORM

Name: _____ Gender: _____ Date _____

Home Address: _____

School: _____ Grade: _____ Time of Accident: _____

Place of Accident: _____

Nature of Injury: _____

Part of Body Injured: _____

Degree of Injury: _____

Description of Accident: _____

Staff Member in Charge at Time of Accident: _____ Present at accident? _____

Was the school notified? _____ When? _____ By whom? _____

IMMEDIATE ACTION TAKEN

First Aid: _____ By: _____

Sent to School Nurse: _____ By: _____

Sent Home: _____ By: _____

Sent to Physician: _____ By: _____ Name of Physician: _____

Sent to Hospital: _____ By: _____ Name of Hospital: _____

PLEASE FILL OUT IF STUDENT ACCIDENT

Name of Parent/Guardian (or other individual) notified: _____

When: _____ How: _____ By Whom: _____

PLEASE FILL OUT IF EMPLOYEE ACCIDENT

Witnesses: _____

Recommendations for preventing future accidents of this type: _____

WHEN THIS FORM IS COMPLETED TO THIS POINT SAVE IT—IF IT IS A STUDENT ACCIDENT PLEASE ATTACH IN AN EMAIL TO THE SCHOOL NURSE. EMPLOYEE ACCIDENT FORMS ARE TO GO TO THE BUSINESS MANAGER.

SCHOOL NURSE FOLLOW-UP:

Comments/Treatment: _____

BUSINESS MANAGER FOLLOW-UP:

Employee's Total Days Lost from Work: _____

School Nurse Signature: _____ Date: _____

Business Manager Signature: _____ Date: _____

Administrator Signature: _____ Date: _____