



ACCIDENT/ILLNESS REPORT

This form should be completed on any occurrence which results in injury or illness.

PERSONAL DATA

Name of Person Injured _____ Date of Birth _____ / _____ / _____ Male Female
MO. DAY YR.

Name of School Attends/Employed _____ Grade Level/Dept. _____

Parent/Guardian Name(s) _____

Home Address _____
STREET CITY STATE ZIP

Home Phone _____ Business Phone _____ Parents Contacted Yes No

ACCIDENT DESCRIPTION

Date of Accident _____ / _____ / _____ Time of Accident _____ AM PM Date Reported _____ / _____ / _____
MO. DAY YR. MO. DAY YR.

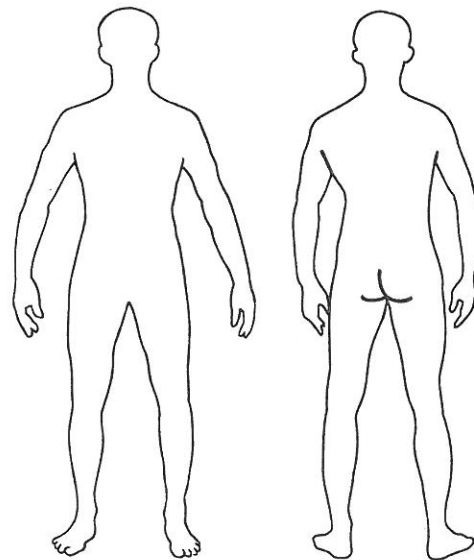
Location of Accident Classroom Gymnasium Cafeteria Hallway School Grounds Other _____

Give a Detailed Description of Accident _____

SIGNATURE OF SUPERVISOR/TEACHER _____

PARTS OF BODY INJURED

HEAD/NECK	UPPER EXTREMITIES	LOWER EXTREMITIES	TRUNK
<input type="checkbox"/> Skull	<input type="checkbox"/> Shoulder(s) R L	<input type="checkbox"/> Hip(s) R L	<input type="checkbox"/> Upper back
<input type="checkbox"/> Face	<input type="checkbox"/> Upper arm(s) R L	<input type="checkbox"/> Thigh(s) R L	<input type="checkbox"/> Lower back
<input type="checkbox"/> Neck	<input type="checkbox"/> Elbow(s) R L	<input type="checkbox"/> Knee(s) R L	<input type="checkbox"/> Collarbone
<input type="checkbox"/> Ear(s) R L	<input type="checkbox"/> Forearm(s) R L	<input type="checkbox"/> Lower leg(s) R L	<input type="checkbox"/> Chest
<input type="checkbox"/> Eye(s) R L	<input type="checkbox"/> Wrist(s) R L	<input type="checkbox"/> Ankle(s) R L	<input type="checkbox"/> Lung(s)
<input type="checkbox"/> Nose	<input type="checkbox"/> Hand(s) R L	<input type="checkbox"/> Foot R L	<input type="checkbox"/> Ribs
<input type="checkbox"/> Teeth	<input type="checkbox"/> Finger(s) R L	<input type="checkbox"/> Toe(s) R L	<input type="checkbox"/> Pelvis
<input type="checkbox"/> Mouth			<input type="checkbox"/> Internal



MARK INJURED AREAS OF BODY

SPECIFIC TYPE OF INJURY

<input type="checkbox"/> Amputation	<input type="checkbox"/> Concussion	<input type="checkbox"/> Inflammation	<input type="checkbox"/> Puncture
<input type="checkbox"/> Asphyxiation	<input type="checkbox"/> Cut/Laceration/Abrasion	<input type="checkbox"/> Ligaments/Cartilage	<input type="checkbox"/> Shock (electrical)
<input type="checkbox"/> Bite	<input type="checkbox"/> Dislocation	<input type="checkbox"/> Overheated	<input type="checkbox"/> Sprain/Strain
<input type="checkbox"/> Bruise/Contusion	<input type="checkbox"/> Fracture	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Sting
<input type="checkbox"/> Burn/Scald	<input type="checkbox"/> Frostbite	<input type="checkbox"/> Poisoning (solid, liquid, gas, vapor)	<input type="checkbox"/> Teeth injury
<input type="checkbox"/> Chest Pains	<input type="checkbox"/> Hearing Loss		<input type="checkbox"/> Vision loss
<input type="checkbox"/> Other (specify) _____			

MEDICAL ATTENTION

First aid administered. Describe first aid given _____

SIGNATURE OF PERSON ADMINISTERING FIRST AID _____

Taken to school nurse Taken to doctor/clinic Taken home, by whom _____ Returned to normal activity

Ambulance called Taken to hospital, by whom _____ ADMITTED RELEASED

NAME OF HOSPITAL/DOCTOR _____ ADDRESS OF HOSPITAL/DOCTOR _____

Witness(es) to Accident _____
NAME ADDRESS PHONE

Final Results _____ Signature _____
NAME OF PERSON FILING REPORT DATE