# 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 ____/____/____ (MO. DAY YR.) ☐ Male ☐ Female

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 ____/____/____ (MO. DAY YR.) Time of Accident _____ ☐ AM ☐ PM Date Reported ____/____/____ (MO. DAY YR.)

Location of Accident ☐ Classroom ☐ Gymnasium ☐ Cafeteria ☐ Hallway ☐ School Grounds ☐ Other _____

Give a Detailed Description of Accident _____

_____

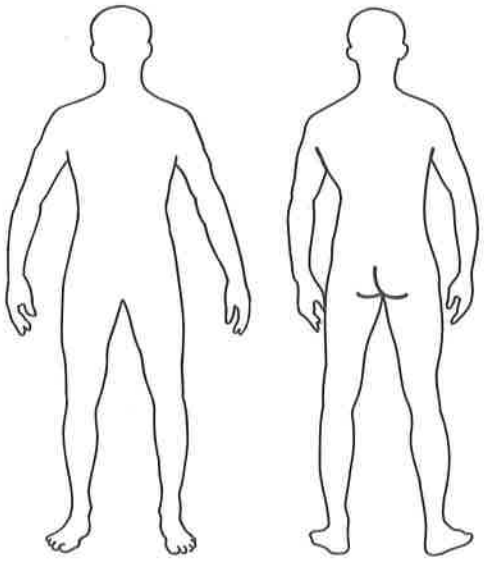
_____

_____

_____ SIGNATURE OF SUPERVISOR/TEACHER

**PARTS OF BODY INJURED**

| HEAD/NECK | UPPER EXTREMITIES | LOWER EXTREMITIES | TRUNK |
|---|---|---|---|
| ☐ Skull | ☐ Shoulder(s) R L | ☐ Hip(s) R L | ☐ Upper back |
| ☐ Face | ☐ Upper arm(s) R L | ☐ Thigh(s) R L | ☐ Lower back |
| ☐ Neck | ☐ Elbow(s) R L | ☐ Knee(s) R L | ☐ Collarbone |
| ☐ Ear(s) R L | ☐ Forearm(s) R L | ☐ Lower leg(s) R L | ☐ Chest |
| ☐ Eye(s) R L | ☐ Wrist(s) R L | ☐ Ankle(s) R L | ☐ Lung(s) |
| ☐ Nose | ☐ Hand(s) R L | ☐ Foot R L | ☐ Ribs |
| ☐ Teeth | ☐ Finger(s) R L | ☐ Toe(s) R L | ☐ Pelvis |
| ☐ Mouth | _____ | _____ | ☐ Internal |



MARK INJURED AREAS OF BODY

**SPECIFIC TYPE OF INJURY**

| | | | |
|---|---|---|---|
| ☐ Amputation | ☐ Concussion | ☐ Inflammation | ☐ Puncture |
| ☐ Asphyxiation | ☐ Cut/Laceration/Abrasion | ☐ Ligaments/Cartilage | ☐ Shock (electrical) |
| ☐ Bite | ☐ Dislocation | ☐ Overheated | ☐ Sprain/Strain |
| ☐ Bruise/Contusion | ☐ Fracture | ☐ Paralysis | ☐ Sting |
| ☐ Burn/Scald | ☐ Frostbite | ☐ Poisoning (solid, liquid, gas, vapor) | ☐ Teeth injury |
| ☐ Chest Pains | ☐ Hearing Loss | | ☐ Vision loss |

☐ 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

_____ NAME ADDRESS PHONE

Final Results _____ Signature _____ NAME OF PERSON FILING REPORT DATE

WHITE - NURSE/OFFICE CANARY - PARENT/GUARDIAN

1026-Hammond & Stephens, Fremont NE