Accident Report

This form is to be completed by the appropriate employee(s) as soon as possible after an accident occurs. Please Print or Type.

District Name _____ School Name _____
Principal's Name _____ School Phone _____
Date of Accident: _____ Time: ____ ☐ AM ☐ PM Supervising Employee _____

Claimant's Name _____ _____ _____
Last Name ***First Name*** ***Middle Initial***
Claimant's Address _____ _____ _____
City ***State*** ***ZIP Code***
Claimant's SS # _____ Home Phone Number (_____) _____
Claimant's Age _____ Date of Birth _____ Sex _____ Grade _____
Parent's Name (if student) _____ Work Phone Number (_____) _____

Nature of Injury	
☐ Scratch	☐ Concussion
☐ Fracture	☐ Head Injury
☐ Bruise	☐ Sprain/Strain
☐ Burn	☐ Cut/Puncture
☐ Dislocation	☐ Bite
☐ Other _____	

Place of Accident	
☐ Classroom	☐ Gymnasium
☐ Hallway	☐ Parking Lot
☐ Bathroom	☐ Sidewalk
☐ Cafeteria	☐ Stairs
☐ Playground	☐ Athletic Field
☐ Other _____	

Body Part Injured		
☐ Ankle	☐ Foot	☐ Leg
☐ Arm	☐ Face	☐ Nose
☐ Back	☐ Finger	☐ Teeth
☐ Neck	☐ Hand	☐ Wrist
☐ Eye	☐ Knee	☐ Shoulder
☐ Other _____		

Describe accident and injury in detail (attach additional description as necessary):_____

_____

_____

Were efforts made to contact the parent/guardian about the accident? ☐ Yes ☐ No

Was first aid administered? ☐ Yes ☐ No By whom? _____

Was the student ☐ Sent home ☐ Sent to physician ☐ Sent to hospital

Is student covered by Student Accident Insurance? ☐ Yes ☐ No If "yes," please list Company Name, address, and phone number _____

If medical or hospital treatment was required, please complete the following information. (Attach a copy of medical bills, if available.)

Name and address of doctor or hospital _____

Witnesses (Name, Address, and Phone) _____

_____

Signature/Name of Person Completing the Report_____
Date_____