SUWANNEE COUNTY DISTRICT SCHOOLS
ACCIDENT/INCIDENT REPORT FORM

Instructions: Teacher or employee witnessing the accident/incident should complete this form immediately and fax to Claire Green, Finance Department (364-2136 fax). SEND HARD COPY AFTER SIGNATURES ARE OBTAINED. All witnesses to accident/incident are to submit a written statement to attach to this form.

INJURED PERSON'S NAME: _____

SCHOOL/SITE: _____ GRADE: _____ DATE OF BIRTH: _____ SEX: ☐M ☐F

NAME OF PARENT OR GUARDIAN(if applicable):_____

MAILING ADDRESS: _____

PARENTS WORK PHONE: _____ HOME PHONE: _____

DATE OF ACCIDENT: | TIME: ☐AM ☐PM

PLACE OF ACCIDENT:

ADULT WITNESS: | SUPERVISING TEACHER:

NATURE OF INJURY

Abrasion	Fracture
Amputation	Laceration
Asphyxiation	Poisoning
Bite	Puncture
Bruise	Scalds
Burn	Scratch
Concussion	Shock (Elec)
Cut	Sprain
Dislocation	Other (Specify)

PART OF BODY INJURED

Abdomen	Eye	Leg
Ankle	Face	Mouth
Arm	Finger	Wrist
Back	Foot	Nose
Chest	Hand	Scalp
Ear	Head	Tooth
Elbow	Knee	Other

DESCRIPTION OF THE ACCIDENT

List specifically unsafe acts and unsafe conditions existing. Specify any tool, machine or equipment involved.

How did accident happen?_____

_____

_____

_____

_____

What was student doing?_____

_____

Where was the student?_____

_____

NAMES OF OTHERS INVOLVED IN ACCIDENT:_____

_____

IMMEDIATE ACTION TAKEN

First Aid Treatment _____ by (name) _____

Sent to school nurse_____ by (name) _____

Sent home _____ by (name) _____

Sent to Physician _____ by (name) _____

Physician's name _____

Sent to hospital _____ by (name) _____

Name of hospital _____

WAS PARENT NOTIFIED? ☐ YES ☐ NO ☐ N/A TIME: ☐ AM ☐ PM

NAME OF PERSON NOTIFIED:

BY WHOM?

ACTION REQUESTED BY PERSON NOTIFIED:_____

_____

SIGNATURE OF PERSON COMPLETING FORM (WITNESS):

SIGNATURE OF SCHOOL OFFICIAL:

TITLE: DATE SIGNED:

5100-002

Revised: 9/28/2010