

SUWANNEE COUNTY DISTRICT SCHOOLS ACCIDENT/INCIDENT REPORT FORM

Instructions: Teacher or employee witnessing the accident/incident should complete this form immediately and fax to Lorie Norris, Finance Department at (386) 364-2635. 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: <input type="checkbox"/> M <input type="checkbox"/> F				
NAME OF PARENT OR GUARDIAN(if applicable): _____				
MAILING ADDRESS: _____				
PARENTS WORK PHONE: _____		HOME PHONE: _____		
DATE OF ACCIDENT: _____		TIME: <input type="checkbox"/> AM <input type="checkbox"/> PM		
PLACE OF ACCIDENT: _____				
ADULT WITNESS: _____		SUPERVISING TEACHER: _____		
NATURE OF INJURY	Abrasion	Fracture	<p style="text-align: center;">DESCRIPTION OF THE ACCIDENT</p> <p style="text-align: center;">List specifically unsafe acts and unsafe conditions existing. Specify any tool, machine or equipment involved.</p> <p>How did accident happen? _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>What was student doing? _____</p> <p>_____</p> <p>Where was the student? _____</p> <p>_____</p>	
	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	
	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? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A TIME: <input type="checkbox"/> AM <input type="checkbox"/> 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