

# Student Accident Report Form

Meade School District 46-1



## Part A: Information on **ALL** Accidents

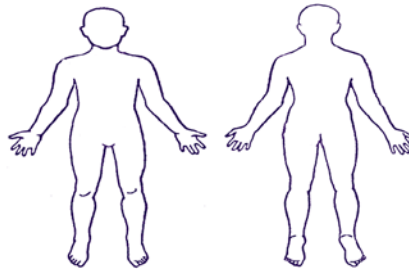
Please fill out as completely as possible in **blue or black ink**

- 1. Name: \_\_\_\_\_ Gender: M\_\_\_ F\_\_\_
- 2. Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_
- 3. Home Address: \_\_\_\_\_ (street)  
\_\_\_\_\_ (city, state)
- 4. Phone #: \_\_\_\_\_ (home)  
\_\_\_\_\_ (cell & guardian name)
- 5. School: \_\_\_\_\_ Grade: \_\_\_\_\_
- 6. Date: \_\_\_\_\_ Time: \_\_\_\_\_
- 7. Place of Accident: School Building\_\_\_ School Grounds\_\_\_ To or From School\_\_\_ Elsewhere\_\_\_

- 8. Type of Injury: Abrasion\_\_\_ Amputation\_\_\_ Asphyxiation\_\_\_  
Bite\_\_\_ Bruise\_\_\_ Burn\_\_\_  
Concussion\_\_\_ Cut\_\_\_ Dislocation\_\_\_  
Fracture\_\_\_ Laceration\_\_\_ Poisoning\_\_\_  
Puncture\_\_\_ Scald\_\_\_ Scratch\_\_\_  
Shock\_\_\_ Sprain\_\_\_ Strain\_\_\_  
Other (specify): \_\_\_\_\_

- Where:
- Abdomen\_\_\_ Ankle\_\_\_ Arm\_\_\_
  - Back\_\_\_ Chest\_\_\_ Ear\_\_\_
  - Elbow\_\_\_ Eye\_\_\_ Face\_\_\_
  - Finger\_\_\_ Foot\_\_\_ Hand\_\_\_
  - Head\_\_\_ Knee\_\_\_ Leg\_\_\_
  - Mouth\_\_\_ Nose\_\_\_ Scalp\_\_\_
  - Tooth\_\_\_ Wrist\_\_\_
  - Other (specify): \_\_\_\_\_

### Mark Injury Location:



- Degree of Injury: Non-Disabling\_\_\_ Temporary Disability\_\_\_  
Permanent Impairment\_\_\_ Death\_\_\_

Total Days of School Missed: \_\_\_\_\_ (To be filled in when student returns)

**Description of Accident:** How did the accident happen? What was student or adult doing? Where was student or adult? Specify any tool, machine/equipment involved.

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## Part B: Additional Information

Please fill out as completely as possible **in blue or black ink**

### 9. Supervisor in Charge When Accident Occurred:

\_\_\_\_\_ (Full Name)

Present at Scene of Accident: Yes \_\_\_\_\_ No \_\_\_\_\_

10. First Aid Treatment \_\_\_\_\_ By: \_\_\_\_\_ (name)

Sent to School Nurse \_\_\_\_\_ By: \_\_\_\_\_ (name)

Sent to Physician \_\_\_\_\_ By: \_\_\_\_\_ (name)

Physician: \_\_\_\_\_ (name)

Sent to Hospital \_\_\_\_\_ By: \_\_\_\_\_ (name)

Hospital: \_\_\_\_\_ (name)

11. Was a Parent/Guardian Notified: Yes \_\_\_\_\_ No \_\_\_\_\_ Time: \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_

Relationship to Injured: \_\_\_\_\_

By Whom: \_\_\_\_\_ (name)

### 12. Information of Person(s) Completing This Form

Person #1 - Full Name: \_\_\_\_\_

Job Title: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ (home) \_\_\_\_\_ (cell)

Signature: \_\_\_\_\_

Person #2 (If Needed) - Full Name: \_\_\_\_\_

Job Title: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ (home) \_\_\_\_\_ (cell)

Signature: \_\_\_\_\_

### Additional Information:

*Initial treatment given? Follow-up with administration? Did a guardian pick-up injured?*

### To Be Completed by Building Admin Assistant:

Received: \_\_\_\_\_ (date/initials)

Principal signature: \_\_\_\_\_ (date/initials)

Faxed to business office: \_\_\_\_\_ (date/initials)

Scanned to business office: \_\_\_\_\_ (date/initials)