

STUDENT ACCIDENT / INJURY AND INCIDENT REPORT

Supervisor or witness at accident scene shall fill out report & return to the nurses office immediately!

Independent School District No. 2909
Rock Ridge Public Schools

Date of Accident: _____ Time: _____ a.m. p.m. School: _____

Name of Student: _____ Grade: ____ Sex: M F Phone: _____

Parent/Guardian: _____ Address: _____

Part of body injured (arm, leg, etc.): _____

Describe injury (bump, bruise, fracture, etc.): _____

Describe how accident occurred, individuals/witness involved: _____

(if additional space required, please use reverse side)

Was time lost from school? No ___ Yes ___ No. of days: _____ Date returned: _____

Location of accident:

School: Grounds ___ Building ___ Location in Building (Room No.): _____

Non-School: Home ___ Other: _____

Was parent/guardian notified? Yes ___ No ___ By whom? _____

Was area supervised? Yes ___ No ___ Name of Supervisor/Title: _____

Was first-aid given? Yes ___ No ___ By whom? _____ Title: _____

Describe what first aid, treatment, etc., was given: _____

Was physician/medical attention required? Yes ___ No ___ Ambulance? Yes ___ No ___

Name of Professional: _____ Place of treatment: _____

Signature: _____ Date: _____
(Supervisor or Witness)

Additional comments or follow-up information:

Copies to: White - Superintendent
Canary - School Nurse
Pink - Principal of Building
Business Manager

Reported by: _____