

NORTH EAST INDEPENDENT SCHOOL DISTRICT
STUDENT ACCIDENT/INCIDENT REPORT FORM

CAMPUS _____ I.D. # _____

STUDENT INFORMATION	
NAME _____ GRADE _____ SEX _____ SSN _____	
DATE OF INJURY _____ TIME _____ SENT TO CLINIC BY: _____ TIME _____	
SCHOOL INS. <input type="checkbox"/> YES <input type="checkbox"/> NO ADULT SUPERVISING AT TIME OF INJURY _____	
PRINTED	SIGNATURE

CAUSE	ACCIDENT SCENE		
<input type="checkbox"/> ASSAULT/FIGHT <input type="checkbox"/> BITE <input type="checkbox"/> KICKED <input type="checkbox"/> SLIP/FALL <input type="checkbox"/> STRUCK BY <input type="checkbox"/> TRIPPED OTHER _____	<input type="checkbox"/> PLAYGROUND <input type="checkbox"/> PLAYGROUND EQUIP. (_____) <input type="checkbox"/> GYM EQUIPMENT <input type="checkbox"/> GYMNASIUM <input type="checkbox"/> PHYSICAL EDUCATION <input type="checkbox"/> SHOP <input type="checkbox"/> SHOP EQUIPMENT	<input type="checkbox"/> CLASSROOM <input type="checkbox"/> CAFETERIA <input type="checkbox"/> RESTROOM <input type="checkbox"/> HALLS <input type="checkbox"/> RECESS <input type="checkbox"/> PARKING LOT	<input type="checkbox"/> SPECIAL ACTIVITIES/TRIPS <input type="checkbox"/> ATHLETICS (_____) <input type="checkbox"/> TO SCHOOL <input type="checkbox"/> FROM SCHOOL <input type="checkbox"/> BUS <input type="checkbox"/> PRIVATE VEHICLE <input type="checkbox"/> BIKE <input type="checkbox"/> PEDESTRIAN OTHER _____

STATEMENT DESCRIBING ACCIDENT: _____

NATURE OF INJURY (POSSIBLE)	LOCATION OF INJURY (R OR L)					
<input type="checkbox"/> ABRASION <input type="checkbox"/> BRUISE <input type="checkbox"/> BURN <input type="checkbox"/> CONCUSSION <input type="checkbox"/> DISLOCATION OTHER _____	<input type="checkbox"/> FRACTURE <input type="checkbox"/> LACERATION <input type="checkbox"/> PUNCTURE <input type="checkbox"/> SCRATCH <input type="checkbox"/> SPRAIN	<input type="checkbox"/> ABDOMEN <input type="checkbox"/> ANKLE <input type="checkbox"/> ARM <input type="checkbox"/> BACK <input type="checkbox"/> CHEST	<input type="checkbox"/> EAR <input type="checkbox"/> ELBOW <input type="checkbox"/> EYE <input type="checkbox"/> FACE <input type="checkbox"/> FINGER	<input type="checkbox"/> FOOT <input type="checkbox"/> HAND <input type="checkbox"/> HEAD <input type="checkbox"/> HIP <input type="checkbox"/> KNEE	<input type="checkbox"/> LEG <input type="checkbox"/> MOUTH/TEETH <input type="checkbox"/> NECK <input type="checkbox"/> NOSE <input type="checkbox"/> SHOULDER	<input type="checkbox"/> STOMACH <input type="checkbox"/> TOE <input type="checkbox"/> WRIST
OTHER _____	OTHER _____	OTHER _____	OTHER _____	OTHER _____	OTHER _____	OTHER _____

TREATMENT ADMINISTERED	
FIRST AID GIVEN: _____	
ADMINISTERED BY: _____	
PARENTS NOTIFIED _____ BY _____	REFERRED TO PHYSICIAN _____ EMS CALLED _____
TIME _____	TIME _____
PICKED UP BY: _____	TRANSPORTED <input type="checkbox"/> YES <input type="checkbox"/> NO
TIME _____	
PHYSICIAN'S DIAGNOSIS AND TREATMENT: _____	
CLINIC/HOSPITAL _____	
FOLLOW UP: DATE RETURNED TO SCHOOL _____ DAYS ABSENT _____ PHYSICIAN: _____	
SCHOOL NURSE'S SIGNATURE _____	DATE _____
PRINCIPAL'S SIGNATURE _____	DATE _____