

INJURIES

All student and/ or employee injuries are to be reported immediately to the respective building principal for disposition. In addition, all employees of the School District of Independence must complete an accident report and file with the respective principal. The school does not subscribe to any benefit program, and all costs incurred because of accidental injuries must be taken care of by the injured.

\*Attachments: 1 Accident Report Form

Revised and adopted December 27, 1993

Reaffirmed annually December 26, 1994 through December 23, 1996

Revised December 30, 1997

Reaffirmed annually December 21, 1998 through December 7, 2011

Revised December 6, 2017

**REPORT OF STUDENT INJURY AND FIRST AID FORM**

**STUDENT INFORMATION**

Student Name		Date	
Date of Birth		Grade	Male      Female
Date of Illness/ Injury		Time of Illness/ Injury	

**SCHOOL INFORMATION**

School:	Principal:
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**ACCIDENT INFORMATION (CIRCLE THE APPROPRIATE CHOICE)**

Location of accident:		When did accident occur?	
Athletic Field	Playground	After School	Lunch
Bus	Pool	Athletic Practice	Other _____
Cafeteria	Restroom	Athletic Team Competition	Physical Education Class
Classroom	Stairway	Before School	Recess
Gymnasium	Vocational/Shop Lab	Class Change	Unknown
Hallway	Other _____	During Class	
Parking Lot		Field Trip	

**SURFACE (CIRCLE ALL THAT APPLY)**

Asphalt	Gravel	Sand
Carpet	Gymnasium floor	Snow
Concrete	Ice	Synthetic Surface
Dirt	Mat(s)	Tile
Grass	Other _____	Wood Chips/Mulch

**TYPE OF INJURY (CIRCLE ALL THAT APPLY)**

Head	Jaw	Elbow	Chest/Ribs	Leg	Abrasion	Cut/Laceration	Other
Eye	Chin	Forearm	Back	Knee	Scrape	Dislocation	
Ear	Neck/Throat	Wrist	Abdomen	Ankle	Bite	Fracture	
Nose	Collarbone	Hand	Groin	Foot	Bump/Swelling	Pain/Tenderness	
Mouth/Lips	Shoulder	Finger	Genitals	Toe	Bruise	Puncture	

**CONTRIBUTING FACTORS (CIRCLE ALL THAT APPLY)**

Animal Bite	Contact with Hot Toxic Substance	Foreign Body/Object	Slipped	Unknown
Collision w/Object	Drug, Alcohol or Other Substance Involved	Hit with Thrown Object	Struck by Auto, Bike, etc.	Weapon
Collision with Person	Fall	Other _____	Struck by Object	

		–	(bat, swing, etc.)	
Compression/Pinch	Fighting	Overextension/Twisted	Tripped	

**DESCRIPTION OF THE INCIDENT**

Witnessed by:

**STAFF INVOLVED (CIRCLE THE APPROPRIATE STAFF)**

Assistant Staff	Health Assistant
Bus Driver	Principal
Coach	Secretary
Custodian	Teacher
Cafeteria Staff	Other _____

**INCIDENT RESPONSE**

First Aid	Time:	By Whom:
Parent/Guardian Notified	Time:	By Whom:
Unable to Contact Parent/Guardian	Time:	By Whom:

**CIRCLE APPROPRIATE CHOICE(S)**

Parents deemed no medical action necessary	Return to class	Sent/Taken Home
Called EMS/911	Taken to healthcare provided/clinic/hospital/UC	Health Assistant Called
Other: _____ _____		

<b>CARE PROVIDED TO THE STUDENT</b>


SIGNATURE OF STAFF PERSON COMPLETING THE FORM:	DATE:	
SIGNATURE OF PRINCIPAL:	DATE:	
SIGNATURE OF HEALTH ASSISTANT:	DATE:	