



# STUDENT INCIDENT REPORT

**NOTE:** A school employee either witnessing an incident or supervising at the time of an incident should immediately complete and submit this form to the Risk Management Office. In case of a serious injury, a TELEPHONE REPORT is to be made immediately to the Risk Management Office.

This form is a confidential, internal, document: Its contents are not be shared or copied for any persons who are not school district employees and/or their legal representative.

School \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Injured Student's Name \_\_\_\_\_ Grade \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Date of Incident \_\_\_\_\_ Time of Incident \_\_\_\_\_ a.m. \_\_\_\_\_ p.m. \_\_\_\_\_

Location (be specific if at school site) \_\_\_\_\_

Describe how the incident occurred \_\_\_\_\_

Who was in charge at the time of the incident? (Employee's name) \_\_\_\_\_

Was he/she present at that time? Yes  No  Did the injured student violate school rules? Yes  No

Witness Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Apparent Nature of Injury: \_\_\_\_\_

- |                                    |                                     |   |                               |                                 |                               |                                  |
|------------------------------------|-------------------------------------|---|-------------------------------|---------------------------------|-------------------------------|----------------------------------|
| Abrasion <input type="checkbox"/>  | Fracture <input type="checkbox"/>   | Strain/Sprain <input type="checkbox"/>  | Head <input type="checkbox"/> | Finger <input type="checkbox"/> | Arm <input type="checkbox"/>  | Abdomen <input type="checkbox"/> |
| Contusion <input type="checkbox"/> | Cut <input type="checkbox"/>        | Dislocation <input type="checkbox"/>    | Neck <input type="checkbox"/> | Eye <input type="checkbox"/>    | Leg <input type="checkbox"/>  | Hand <input type="checkbox"/>    |
| Internal <input type="checkbox"/>  | Concussion <input type="checkbox"/> | Teeth (Broken) <input type="checkbox"/> | Back <input type="checkbox"/> | Chest <input type="checkbox"/>  | Face <input type="checkbox"/> | Foot <input type="checkbox"/>    |

Other (Explain) \_\_\_\_\_

First Aid procedure used? \_\_\_\_\_ By Whom? \_\_\_\_\_

Who was notified? \_\_\_\_\_ Relationship? \_\_\_\_\_

If injured student left school, to whom released? \_\_\_\_\_

Does injured person have medical insurance?  Yes  No If yes, who is the provider \_\_\_\_\_

Does injured person have dental insurance?  Yes  No If yes, who is the provider \_\_\_\_\_

Did anyone contact the school after the incident?  Yes  No If yes, who \_\_\_\_\_

Report completed by \_\_\_\_\_ Date \_\_\_\_\_

Report approved by (School Administrator) \_\_\_\_\_ Date \_\_\_\_\_