

# STUDENT ACCIDENT / INJURY REPORT FORM

Independent School District #535 ☺ 10 - 9 1/2 Street SE ☺ Rochester, MN 55904

The purpose of this form is to reduce accidents among children and thereby avoiding litigation against staff members of the school district. It is necessary when accidents occur that a staff member completes this form carefully and submits the original to Insurance Services at MSB as soon as possible. You must retain a photocopy of this report in your school's health office.

<b>Name</b> _____ <small>Last name of Injured Student                      First name</small>		<b>Students Age</b> _____	<b>Students Grade</b> _____
<b>Contact</b> _____ <small>Parent/Guardian's Name</small>		_____ <small>Home Address</small>	_____ <small>Phone Number</small>
<b>School Building</b> _____	<b>School Phone#</b> _____		
<b>Date of Accident/Injury</b> _____	<b>Time of Injury</b> _____	<b>Where?</b> _____ <small>(example: playground, classroom, cafeteria – be specific)</small>	
<b>Accident Occurred During:</b>			
<input type="checkbox"/> Classtime (if yes, which class?) _____			
<input type="checkbox"/> Before School <input type="checkbox"/> After School <input type="checkbox"/> Extra Curricular/Sporting Event <input type="checkbox"/> Field Trip			
<input type="checkbox"/> Passing Time <input type="checkbox"/> Lunch <input type="checkbox"/> Recess			
<input type="checkbox"/> Other _____			
<b>Type of Injury</b> _____ <small>(example: bruise, cut, scrape, bite)</small>	<b>Body Part(s) Injured</b> _____ <small>(example: right arm, low back, forehead)</small>		
<b>Describe in detail the accident / injury:</b> _____ _____ _____ _____ _____			
<b>First adult(s) to see or hear the accident:</b> _____			
<b>Who else was present at the time of the accident?</b> _____			
<b>First Aid given?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If so, by whom?</b> _____			
<b>What first aid measures were given?</b> <input type="checkbox"/> Rest <input type="checkbox"/> Ice <input type="checkbox"/> Bandage <input type="checkbox"/> Other (describe below) _____ _____			
<b>Was there blood exposure?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If so, by whom?</b> <input type="checkbox"/> Staff <input type="checkbox"/> Student			
<b>Name(s):</b> _____ <small>(if staff, report to Insurance, 328-4280)</small>			
<b>Did the child remain at site?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If not, where taken:</b> _____ <b>By whom?</b> _____			
<b>Were parents notified?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If so, by whom?</b> _____ <b>How?</b> _____			
<b>Follow-up notes:</b>          			
<b>Report completed by:</b> _____		<b>Date of report:</b> _____	
<b>Reviewed by:</b> _____		<b>Date sent to Insurance Services:</b> _____	