

ACCIDENT/INJURY REPORT FORM

Use this form to report any accidents or injuries observed

INFORMATION ABOUT PERSON INJURED	
Full Name	Date of Birth
Parent/Guardian Name(s)	Phone Number

INFORMATION ABOUT THE ACCIDENT/INJURY		
Date of Accident/Injury	Time	Date of Report
Location (circle one) ANK BLN LLK SLP WBL WBY WHS		
Description of Accident/Injury – What Happened and Where? (Be specific)		
Who else was involved?		
Action Taken (check one) <input type="checkbox"/> Continued Activity <input type="checkbox"/> Limited Activity <input type="checkbox"/> Paged/Called Parent <input type="checkbox"/> Sent Home <input type="checkbox"/> 911 Called <input type="checkbox"/> Taken to Hospital/Doctor <input type="checkbox"/> First Aid Given – By: _____		
Describe any additional actions or statements that were taken or made in regard to the accident/injury:		
Were the parents/guardians notified? _____ Yes _____ No		
When were they notified?		
Their response:		
To whom was the individual released?		

WITNESSES (those who were present or observed occurrences)		
Name: _____	Role: _____	Phone: _____
Name: _____	Role: _____	Phone: _____
Name: _____	Role: _____	Phone: _____

REPORTER INFORMATION	
Individual Submitting Report (print name)	
Signature	Date

PARENT INFORMATION	
Parent/Guardian (print name)	
Signature	Date