

### Injury Report Form

This form to be completed by district personnel only

<b>SCHOOL/SITE</b> _____	<b>INJURED PERSON</b> _____
Exact Area/Room _____	Date of Incident _____ Time _____ am pm
Supervisor in Charge _____	Date of Birth _____
Supervisor Title _____	Phone _____
If Witnessed/Name(s) _____	Address _____

**Describe event, actions, conditions and what injured person was doing before incident. If sport injury, specify sport** \_\_\_\_\_

**Injury – describe in detail**

**Care Provided – describe in detail (continue on back if needed)**

Care Provided By \_\_\_\_\_ School Nurse OR if not, Position \_\_\_\_\_

**911 & Medical Provider Information**

911 Called \_\_\_\_\_ If 911 Transport, name of ER \_\_\_\_\_ Admitted Overnight \_\_\_\_\_  
 Sent to Medical Provider \_\_\_\_\_ Name of Medical Provider \_\_\_\_\_

**STUDENT INJURY** Grade \_\_\_\_\_ Pupil # \_\_\_\_\_

Notified Parent/Guardian / Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Home w Parent/Guardian \_\_\_\_\_ Home with Other / Name \_\_\_\_\_

**EMPLOYEE INJURY** (Employee injuries must be reported within 7 days)

Employee # \_\_\_\_\_ Occupation \_\_\_\_\_ Time Work Begins \_\_\_\_\_ Work Ends \_\_\_\_\_  
 Sent Home \_\_\_\_\_ Driven By (Name) \_\_\_\_\_  
 Time lost from work \_\_\_\_\_ If yes, number of days gone \_\_\_\_\_

**VISITOR INJURY** Parent/Guardian \_\_\_\_\_ Other / Specify \_\_\_\_\_

**Reporting Employee** \_\_\_\_\_  
 Print Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

**Principal Review** \_\_\_\_\_  
 Print Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

**Send Copies To:** Principal and/or Department Supervisor      Staff Injury: send copy to HR/Workers Comp  
 If Blood Exposure or Head Injury Report: send copy to Health Services      Student or Visitor Injury: send copy to Risk Management

