



Health Services

Instruction Department

Accident/Incident Report

Date: _____

Name: _____

DOB: _____

ID#: _____

Campus: _____

Grade: _____

Homeroom: _____

Student Staff Visitor Supervised Activity? Yes No

Time of accident/incident: _____ Parent/guardian notified at: _____

Location: classroom gym playground cafeteria other _____

Description of how accident/incident occurred: _____

If eyes were involved, was a protective device worn? Yes No N/A

Signature of witness

Signature of witness

Assessment: _____

Intervention: _____

Recommendation/referral: _____

Was EMS/911 called? Yes No Time called: _____ Time arrived: _____

Follow-up: _____

Time lost, if any, due to accident/incident: _____

School nurse signature

Administrator signature

- Original to Coordinator of Health Services
- Copies to Student Health Folder and School Nurse's File