

# STUDENT INJURY REPORT FORM

1. School Name: \_\_\_\_\_ 2. Activity: \_\_\_\_\_ 3. Date of Injury: \_\_\_\_\_

4. Student's Name: \_\_\_\_\_ 5. Grade: \_\_\_\_\_ 6. Time of Injury: \_\_\_\_\_

7. Address: \_\_\_\_\_ Telephone: \_\_\_\_\_ ( ) Male ( ) Female

8. Location of Accident: ( ) Classroom ( ) Field ( ) Gym ( ) Locker Room ( ) Game ( ) Practice ( ) Other

9. Body Part Injured:

<u>HEAD</u>	<u>TRUNK</u>	<u>EXTREMITIES</u>	<u>OTHER</u>
<input type="checkbox"/> Ear	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Ankle	<input type="checkbox"/> Lower Arm
<input type="checkbox"/> Eye	<input type="checkbox"/> Back	<input type="checkbox"/> Elbow	<input type="checkbox"/> Lower Leg
<input type="checkbox"/> Face	<input type="checkbox"/> Chest	<input type="checkbox"/> Finger	<input type="checkbox"/> Thumb
<input type="checkbox"/> Head	<input type="checkbox"/> Chest	<input type="checkbox"/> Foot	<input type="checkbox"/> Toes
<input type="checkbox"/> Neck	<input type="checkbox"/> Groin	<input type="checkbox"/> Hand	<input type="checkbox"/> Upper Arm
<input type="checkbox"/> Scalp	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Hip	<input type="checkbox"/> Upper Leg
		<input type="checkbox"/> Knee	<input type="checkbox"/> Wrist

10. Type of Injury:

<input type="checkbox"/> Abrasion	<input type="checkbox"/> Bite	<input type="checkbox"/> Bruise	<input type="checkbox"/> OTHER
<input type="checkbox"/> Burn	<input type="checkbox"/> Concussion	<input type="checkbox"/> Cut	_____
<input type="checkbox"/> Dislocation	<input type="checkbox"/> Fracture	<input type="checkbox"/> Heat	_____
<input type="checkbox"/> Laceration	<input type="checkbox"/> Puncture	<input type="checkbox"/> Scratch	_____
<input type="checkbox"/> Shock	<input type="checkbox"/> Sprain	<input type="checkbox"/> Strain	_____

11. First Aid Given:

<input type="checkbox"/> Applied Dressing	<input type="checkbox"/> Applied Splint	<input type="checkbox"/> Ice	<input type="checkbox"/> OTHER
<input type="checkbox"/> Kept Immobile	<input type="checkbox"/> Stopped bleeding	<input type="checkbox"/> Observed	_____
<input type="checkbox"/> Washed Wound			

12. Action Taken:

<input type="checkbox"/> Parent took home	<input type="checkbox"/> Transfer to hospital	<input type="checkbox"/> Parent took to doctor
<input type="checkbox"/> Returned to sport	<input type="checkbox"/> Parent took to ER	<input type="checkbox"/> Called 911
<input type="checkbox"/> Other: _____		

13. Explanation of Accident:

<input type="checkbox"/> Collision with person	<input type="checkbox"/> Collision with obstacle	<input type="checkbox"/> Fall
<input type="checkbox"/> Hit with object	<input type="checkbox"/> Injury to self	
<input type="checkbox"/> Other: _____		

14. Describe: Describe specifically how the injury happened. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

15. Witness 1: \_\_\_\_\_ Address: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Witness 2: \_\_\_\_\_ Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

16. Form Submitted by: \_\_\_\_\_  
 Signature/Date: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Telephone #: \_\_\_\_\_

Please attach additional comments / information on back of sheet