Student Accident/911 Incident Report

Student Name _____Date _____

Time In Office _____ Time Out of Office_____

Code: (check all that apply)

Bloody Nose	Dislocation	Insect Sting	Sprain
Bruise/Contusion	Eye Problem	Laceration/Cut	Vomiting
Burns	Fracture	Pain/Ache	Other
Concussion	Headache	Scrape/Abrasion	

Disposition (after leaving office) _____

Staff Referred By _____Follow Up Date (return to class) _____

Name of Parent/Guardian Notified _____

Parent Contact Attempt Time _____Parent Contact Made Time _____

Accident Description _____

_____

_____

_____

Injury Description _____

_____

_____

_____

Medical Care Recommended _____

If Transported to Medical Facility Complete:

Medical Facility Taken _____

Picked Up By _____Time Taken _____

Location of Accident_____Follow Up _____

Witnesses_____

All Persons Notified: ☐ Parent/Guardian ☐ School Nurse ☐ Risk Management ☐ Superintendent

Treated By Medical Professional_____ Called 911 _____

Admin Signature _____ Date _____