



STUDENT ACCIDENT REPORT

WAKULLA COUNTY SCHOOL BOARD

Risk Management

THIS FORM IS TO BE COMPLETED BY THE APPROPRIATE EMPLOYEE(S) AS SOON AS POSSIBLE AFTER AN ACCIDENT

District Name: _____ School Name: _____

Address: _____ Principal's Name: _____

School Phone: () _____ Date of Accident: _____ Time: _____ AM ___ PM ___

Supervising Teacher or Employee: _____

Student's Name: _____, _____, _____

Last Name
First Name
Middle Name

Student's Address: _____, _____, _____, _____

Street
City
State
Zip Code

Home Phone Number: () _____

Student's Age: _____ Date of Birth: _____ Sex: ___ Male ___ Female Grade Level: _____

Parent's Name (of student): _____ Work Phone Number: () _____

NATURE OF INJURY	PLACE OF ACCIDENT	BODY PART INJURED
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<p>CHECK ONE OR MORE</p> <p><input type="checkbox"/> Scratch <input type="checkbox"/> Concussion</p> <p><input type="checkbox"/> Fracture <input type="checkbox"/> Head Injury</p> <p><input type="checkbox"/> Bruise <input type="checkbox"/> Sprain</p> <p><input type="checkbox"/> Strain <input type="checkbox"/> Burn</p> <p><input type="checkbox"/> Puncture <input type="checkbox"/> Abrasion</p> <p><input type="checkbox"/> Dislocation <input type="checkbox"/> Bite</p> <p><input type="checkbox"/> Laceration</p> <p><input type="checkbox"/> Other: _____</p>	<p>CHECK ONE OR MORE</p> <p><input type="checkbox"/> Classroom <input type="checkbox"/> Gymnasium</p> <p><input type="checkbox"/> Hallway <input type="checkbox"/> Parking Lot</p> <p><input type="checkbox"/> Bathroom <input type="checkbox"/> Sidewalk</p> <p><input type="checkbox"/> Cafeteria <input type="checkbox"/> Stairs</p> <p><input type="checkbox"/> Playground <input type="checkbox"/> Athletic Field</p> <p><input type="checkbox"/> School Bus <input type="checkbox"/> To/From School</p> <p><input type="checkbox"/> Vocational Shop or Lab</p> <p><input type="checkbox"/> Other: _____</p>	<p>CHECK ONE OR MORE</p> <p><input type="checkbox"/> Ankle <input type="checkbox"/> Foot <input type="checkbox"/> Leg</p> <p><input type="checkbox"/> Arm <input type="checkbox"/> Face <input type="checkbox"/> Nose</p> <p><input type="checkbox"/> Back <input type="checkbox"/> Finger (s) <input type="checkbox"/> Teeth</p> <p><input type="checkbox"/> Neck <input type="checkbox"/> Hand <input type="checkbox"/> Wrist</p> <p><input type="checkbox"/> Eye <input type="checkbox"/> Knee <input type="checkbox"/> Shoulder</p> <p><input type="checkbox"/> Chest <input type="checkbox"/> Hip <input type="checkbox"/> Toes</p> <p><input type="checkbox"/> Left Side <input type="checkbox"/> Right Side</p> <p><input type="checkbox"/> Other: _____</p>
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KIND OF ACCIDENT	ENVIRONMENTAL FACTORS	HUMAN FACTORS
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<p><input type="checkbox"/> Animal bite or insect bite</p> <p><input type="checkbox"/> Collision with student</p> <p><input type="checkbox"/> Contact with hot or toxic substance</p> <p><input type="checkbox"/> Fall or slip</p> <p><input type="checkbox"/> Struck by student/auto/bike etc.</p> <p><input type="checkbox"/> Collision with object</p> <p><input type="checkbox"/> Other: _____</p>	<p><input type="checkbox"/> Crowding <input type="checkbox"/> Doors</p> <p><input type="checkbox"/> Equipment <input type="checkbox"/> Lighting</p> <p><input type="checkbox"/> Hard Surface <input type="checkbox"/> No Handrails</p> <p><input type="checkbox"/> Floors <input type="checkbox"/> Wet/Sandy</p> <p><input type="checkbox"/> Chair <input type="checkbox"/> Ladders</p> <p><input type="checkbox"/> Weather <input type="checkbox"/> Carpeting/Rugs</p> <p><input type="checkbox"/> Safety Guard Removed</p> <p><input type="checkbox"/> Other: _____</p>	<p><input type="checkbox"/> Active game <input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> Horseplay <input type="checkbox"/> Fighting</p> <p><input type="checkbox"/> Preoccupation <input type="checkbox"/> Running</p> <p><input type="checkbox"/> Lack of training or experience</p> <p><input type="checkbox"/> Workplace safety violation</p> <p><input type="checkbox"/> No personal protective equipment</p> <p><input type="checkbox"/> Other: _____</p>
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Were efforts made to contact the parent/guardian about the accident? ___ Yes ___ No Time: _____

Was First Aid administered? ___ Yes ___ No

Were photos take of injury and accident site? ___ Yes ___ No Who has Photos? _____

Was the student sent: ___ Back to Class ___ Home ___ Physician ___ Hospital

By whom (Name): _____

Witnesses (Name, Address, Phone): _____

IF MEDICAL OR HOSPITAL TREATMENT WAS REQUIRED, PLEASE COMPLETE THE FOLLOWING:

Name and address of doctor or hospital: _____

ACTION TAKEN TO PREVENT SIMILAR ACCIDENT

Check one or more

INSTRUCTIONAL:

___ Discussed at staff meeting Date: _____ ___ Discussed in each class as part of regular instruction Date: _____

___ Discussed with parents Date: _____ ___ Personal instruction given to person in charge Date: _____

___ Presented as a subject of assembly program Date: _____

POLICY OR CORRECTIVE ACTION:

___ Environment changes affected. Date: _____ ___ Notified school safety committee. Date: _____

Safety rules amended to prevent recurrence. Date: _____ ___ Supervision (training) Date: _____

District Safety Specialist and/or Facilities/Maintenance Ex Director invited to school to assist in safety program. Date: _____

OTHER:

No action taken, why: _____

Describe accident and injury in detail:

SIGNATURE OF TEACHER

SIGNATURE OF PRINCIPAL

Return completed form to: Jim Griner, Safety and Risk Coordinator,
Wakulla County School District
Call the District Office Immediately If Accident Is Serious:
850.926.0065, #9550