



St. Michael's Country Day School Student Accident Report Form

THIS FORM IS TO BE COMPLETED BY THE APPROPRIATE EMPLOYEE (S) FOLLOWING A SCHOOL ACCIDENT/INJURY OCCURS. PLEASE FORWARD TO SCHOOL NURSE UPON COMPLETION.

(PLEASE PRINT OR TYPE)

Name:		Home Address:	
Phone:		Parents Names	
Sex:	M <input type="checkbox"/> F <input type="checkbox"/>	Age:	Grade:
Date of Accident:		Date of Birth:	
Time of Accident:		Lost School Days:	
Teacher or person(s) in charge or present at time of accident:			

Location of Accident		Nature of Injury		Part of Body Injured	
Athletic Field	Hill House	Fracture	Poisoning	Abdomen	Arm
Cafeteria	Classroom	Burns/Scalds	Allergy	Ankle	Chest
Hallway	Corridor	Head Injury	Cuts/Lacerations	Back	Finger
Playground	Restroom	Dislocation	Sprain/Strain	Eye	Hand
Locker Room	Parking Area	Puncture	Sting/Bite	Face	Knee
Stairs	Sidewalks	Multiple Injuries		Foot	Leg
Other		Other		Head	Mouth

IMMEDIATE ACTION TAKEN

First Aid Treatment	School Nurse called to the field
Sent to School Nurse	
Sent to physician by parents	Physician's Name
EMS called and transported to hospital	Name of Hospital

Family Member notified:	Father <input type="checkbox"/>	Mother <input type="checkbox"/>	Other: <input type="checkbox"/>	Time: <input type="text"/>
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Witnesses:			

Describe incident and/or injury in detail:

Signature of person completing report _____ Date _____
 Nurse signature _____
 Head of School signature _____
 Business Manager _____

