



Injury Report Form

This form to be completed by district personnel only

SCHOOL/SITE _____ Exact Area/Room _____ Supervisor in Charge _____ Supervisor Title _____ If Witnessed/Name(s) _____	INJURED PERSON _____ Date of Incident _____ Time _____ am pm Date of Birth _____ Phone _____ Address _____
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Describe event, actions, conditions and what injured person was doing before incident. If sport injury, specify sport _____

Injury – describe in detail

Care Provided – describe in detail (continue on back if needed)

Care Provided By _____ School Nurse OR if not, Position _____

911 & Medical Provider Information

911 Called _____ If 911 Transport, name of ER _____ Admitted Overnight _____
 Sent to Medical Provider _____ Name of Medical Provider _____

STUDENT INJURY Grade _____ Pupil # _____

Notified Parent/Guardian / Name _____ Phone _____
 Home w Parent/Guardian _____ Home with Other / Name _____

EMPLOYEE INJURY (Employee injuries must be reported within 7 days)

Employee # _____ Occupation _____ Time Work Begins _____ Work Ends _____
 Sent Home _____ Driven By (Name) _____
 Time lost from work _____ If yes, number of days gone _____

VISITOR INJURY Parent/Guardian _____ Other / Specify _____

Reporting Employee _____
 Print Name _____ Signature _____ Date _____

Principal Review _____
 Print Name _____ Signature _____ Date _____

Send Copies To: Principal and/or Department Supervisor

If Blood Exposure or Head Injury Report: send copy to Health Services

Staff Injury: send copy to HR/Workers Comp

Student or Visitor Injury: send copy to Risk Management

