SCHOOL ACCIDENT REPORT

NAME: ___________________________________________ Last Name, First Name, Middle Initial

Date of Accident: ___________ Time (AM/PM): _______ DOB: ___________ GRADE: ___________

Accident Location: ___ Athletic Field ___ GYM ___ Classroom ___ Cafeteria ___ Hallway ___ Stairway ___ School Bus ___ Restroom ___ Playground ___ Other: ______________________

School Activity at Time of Accident:
___ Interscholastic Sport ___________________________ [ ] Game [ ] Practice [ ] Scrimmage
___ Non-Interscholastic ___________________________ [ ] Noon Hour Rec [ ] Intramural
___ School-Sponsored Activity ______________________ [ ] GYM [ ] Classroom [ ] Other

Was the activity supervised by an employee of the district? [ ] YES [ ] NO

Detailed Description of Accident:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Cause of Accident: ___ Collision with person ___ Collision with obstacle ___ Slip or Fall
___ Struck by object ___ Sudden turn, twist, or stop ___ Fighting ___ Bite (human, animal, insect)
___ Contact with hot or toxic substance ___ Other, specify: _________________________________

Nature of Injury (may be completed after medical exam): ___ Abrasion ___ Bruise ___ Burn
___ Concussion ___ Dislocation ___ Fracture ___ Laceration ___ Puncture ___ Sprain, Strain
___ Other, specify: ________________________________

Body Part Injured (indicate right or left as appropriate):
___ Scalp ___ Face ___ Eye ___ Ear ___ Nose ___ Mouth ___ Tooth ___ Neck
___ Chest ___ Abdomen ___ Back ___ Shoulder ___ Upper Arm ___ Lower Arm ___ Elbow
___ Wrist ___ Hand ___ Finger ___ Hip ___ Knee ___ Upper leg ___ Lower leg ___ Foot
___ Toes ___ Other, specify: __________________________________________________________
Marathon Central School District
PO Box 339
Marathon, NY 13803

Was first aid provided? [ ] YES [ ] NO
By whom? ______________________________________________

First Aid given:  ___ice pack  ___applied Band-Aid  ___washed wound  ___stopped bleeding
___applied dressing  ___splinted  ___applied sling  ___observation only
___other, specify: __________________________________________

Further Care:  ___Parent (or other authorized person) transported to home
___Followed up with Acute Care Center/Emergency Department
___Followed up with primary care provider
___Transported from school by ambulance to ___________________________

Name of Hospital

Was a parent/guardian notified? [ ] YES [ ] NO
By whom? ______________________________________________
If no, explain:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Printed Name of Supervising Staff

Title

Date

Signature

Printed Name of School Nurse

Title

Date

Signature