Marathon Central School District
PO Box 339
Marathon, NY 13803

Check One: ___Student
___Employee

SCHOOL ACCIDENT REPORT

NAME: ____

Last First 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:

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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:____

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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:

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____
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Printed Name of Supervising Staff Title Date

Signature

Printed Name of School Nurse Title Date

Signature