



Student Accident/Injury Report

CONFIDENTIAL-ATTORNEY/CLIENT WORK PRODUCT PRIVILEGE

This report is to be completed by district employees. This form is a confidential, internal, document: its contents are not to be shared or copied for any persons who are not district employees and/or their legal representatives.

This report must be completed within 24 hours of an accident involving an injury to Student.

WHO WAS INJURED?

Name of Injured Person: _____ Telephone: _____

Date of Birth: _____ Student ID #: _____ Male ___ Female ___

Person in Charge of Class or Activity: _____ Present at Scene? Yes ___ No ___

WHEN AND WHERE DID THIS HAPPEN?

Date of Injury: _____ Time of Injury: _____ Date Reported: _____ Time Reported: _____

Location of Injury (Campus) _____ Exact location of injury (Building, Room #) _____

Type of injuries and body part(s) injured. Example: "Cut left pinky finger and hurt lower back".

HOW DID THE INJURY OCCUR?

Describe what happened and what the student was doing just prior to the injury. What tools or equipment were involved?

DID ANYONE SEE THE INJURY HAPPEN? Attach statements of each witness.

Names: _____

Do you think someone else caused the injury?

Name: _____ Home Telephone: _____

Home Address: _____ City: _____ Zip: _____

MEDICAL TREATMENT PROVIDED BY:

Health Center ___ Campus Safety ___ EMT ___ Treatment Declined ___ No Treatment ___ Other _____

Describe type of treatment? _____

Did the injured party go to a hospital or clinic? Yes ___ No ___ if so, name of medical facility: _____

CORRECTIVE ACTION

What has been done to correct any condition that might have contributed to the injury or what do you recommend to prevent future accidents of this nature?

Reporting Party Name: _____ Title: _____ Phone Extension _____

Reporting Party Signature: _____ Date: _____

Department Head Name: _____ Signature: _____

Send a completed report to Risk Management and one copy to your division office.