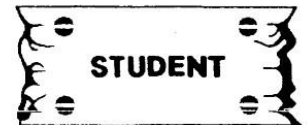


**PRESTON COUNTY SCHOOLS HEALTH SERVICE
ACCIDENT REPORT**



INSTRUCTIONS: READ CAREFULLY. Fill in completely. Use this form to report all accidents to students that occur while they are under the jurisdiction of the school. School jurisdiction accidents, unless otherwise defined by administrative or court ruling, are those occurring while students are on school property, in school buildings, and on the way to and from school.

Name _____ Sex: Male ___ Female ___ Birth Date _____
 Address _____ Phone _____
 School _____ Grade _____
 Teacher _____
 Time of accident: Hour _____ A.M. ___ P.M. ___ Date _____
 Place of Accident: School Building ___ School Grounds ___ To or From School ___ Interscholastic Activities ___

LOCATION	SPECIFIC ACTIVITY
	<input type="checkbox"/> Athletic <input type="checkbox"/> Dressing Room <input type="checkbox"/> School grounds <input type="checkbox"/> Auditorium <input type="checkbox"/> Gymnasium <input type="checkbox"/> Classroom <input type="checkbox"/> Home Economics <input type="checkbox"/> Showers <input type="checkbox"/> Corridor <input type="checkbox"/> Laboratories <input type="checkbox"/> Stairs <input type="checkbox"/> Cafeteria <input type="checkbox"/> Shop _____ <input type="checkbox"/> Other _____

DESCRIPTION OF ACCIDENT: How did the accident happen? What was the student doing? Where was student? List specifically unsafe acts and unsafe conditions existing. Specify any tool, machine or equipment involved. _____

APPARENT NATURE OF INJURY	<input type="checkbox"/> Abrasion <input type="checkbox"/> Fracture <input type="checkbox"/> Amputation <input type="checkbox"/> Laceration <input type="checkbox"/> Bruise <input type="checkbox"/> Puncture <input type="checkbox"/> Burn <input type="checkbox"/> Scratches <input type="checkbox"/> Cut <input type="checkbox"/> Sprain <input type="checkbox"/> Other (Specify) _____	NAME OF ADULT PRESENT AT TIME OF ACCIDENT Witness's Name Address 1. _____ 2. _____ 3. _____ 4. _____

PART OF BODY INJURED	<input type="checkbox"/> Ankle <input type="checkbox"/> Hand <input type="checkbox"/> Arm <input type="checkbox"/> Head <input type="checkbox"/> Back <input type="checkbox"/> Knee <input type="checkbox"/> Elbow <input type="checkbox"/> Leg <input type="checkbox"/> Eye <input type="checkbox"/> Nose <input type="checkbox"/> Face <input type="checkbox"/> Scalp <input type="checkbox"/> Finger <input type="checkbox"/> Tooth <input type="checkbox"/> Foot <input type="checkbox"/> Wrist <input type="checkbox"/> Other (Specify) _____	IMMEDIATE ACTION TAKEN	FIRST AID GIVEN (describe) _____ _____ _____ _____ First Aid Treatment By(Name) _____ Sent to School Nurse By(Name) _____ Sent Home By(Name) _____ Sent to Physician By(Name) _____ Physician's Name _____ Sent to Hospital By(Name) _____ Name of Hospital _____ How was student transported _____ Sent Back To Class By(Name) _____
	Other Comments: _____		

Was the parent or other individual notified? No ___ Yes ___ When _____ How _____
 Name of individual notified: _____
 By whom? (enter name) _____

FOLLOW-UP
 _____ Date _____
 _____ Principal _____
 _____ Date _____
 _____ School Nurse _____

Total number of days lost from school _____ (If applicable)