

Tangipahoa Parish School System

Accident Report

School Name: _____

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. The report should be made out in duplicate. **Important:** It is essential that the accident be described in sufficient detail to show safe and unsafe acts and conditions present when the accident occurred. (When possible use a checkmark)

1. Name _____ Home Address _____
2. Sex M F Age _____ School _____ Home Room Teacher _____
3. Time of Accident: Hour _____ A.M. P.M. Date _____
4. Place of Accident: School Building School Grounds Interscholastic Athletics School Bus

5.	Apparent Name <input type="checkbox"/> Abrasion <input type="checkbox"/> Bruise <input type="checkbox"/> Burn <input type="checkbox"/> Cut <input type="checkbox"/> Puncture <input type="checkbox"/> Scratches <input type="checkbox"/> Other (Specify) _____	<p style="text-align: center;">Description of Accident</p> How did the accident happen? What was the student doing? Where was the student? Describe injury. _____ _____ _____	
6.	Part Body Injured <input type="checkbox"/> Ankle R-L <input type="checkbox"/> Arm R-L <input type="checkbox"/> Shoulder R-L <input type="checkbox"/> Chest <input type="checkbox"/> Eye R-L <input type="checkbox"/> Face <input type="checkbox"/> Foot R-L <input type="checkbox"/> Hand R-L	<input type="checkbox"/> Head <input type="checkbox"/> Knee R-L <input type="checkbox"/> Leg R-L <input type="checkbox"/> Nose <input type="checkbox"/> Shoulder R-L <input type="checkbox"/> Other (Specify) _____	<p style="text-align: center;">Treatment Given</p> _____ _____ _____ By Whom: _____ Witnesses Name: _____ _____
7.	Immediate Sent Home <input type="checkbox"/> By (name) _____ Sent to Physician <input type="checkbox"/> By (name) _____ Physician's Name _____ Sent to hospital <input type="checkbox"/> By (name) _____ Name of Hospital _____ How was student transported? _____ Insurance claim completed and attached. <input type="checkbox"/> Yes <input type="checkbox"/> No		
8.	Was the parent or other individual notified? <input type="checkbox"/> Yes <input type="checkbox"/> No Time: _____ Persons Name and Phone Number _____		
9.	<p style="text-align: center;">Specific Activity</p> <input type="checkbox"/> Athletic <input type="checkbox"/> Auditorium <input type="checkbox"/> Classroom <input type="checkbox"/> Corridor <input type="checkbox"/> Cafeteria <input type="checkbox"/> Dressing <input type="checkbox"/> Gymnasium <input type="checkbox"/> Home Economics <input type="checkbox"/> Laboratories <input type="checkbox"/> School Grounds <input type="checkbox"/> Shop _____ <input type="checkbox"/> Stairs <input type="checkbox"/> Other _____ Teacher(s) on duty: _____ Other students involved: _____		

Person Making Report _____ Title _____ Date _____
 Principal _____ School Nurse _____
 Additional Comments: _____