



This report provides an accurate record of the injured person’s reported symptoms at the time of injury.

OVERVIEW OF INCIDENT

Date of injury: _____

Time of injury: _____

Name of person injured: _____

Category: ___ Student ___ Faculty/Staff ___ Guest

Grade (if student): _____

Date of Birth: _____

Gender: ___ Female ___ Male

Where the injury occurred: ___ Class ___ P.E. ___ Hallway ___ Lunch ___ Other: _____

Description of incident/injury:

How did the injury occur:

___ Collision with fixed object ___ Collision/Contact with another person ___ Fall /Awkward landing
___ Overbalance ___ Overstretch ___ Slip/Trip

Nature of injury: ___ New ___ Recurring ___ Aggravated ___ Other: _____

Area injured:

Symptoms:

___ Bleeding Nose ___ Blisters ___ Bruising ___ Burn
___ Cardiac Problem ___ Cramp ___ Cut ___ Dislocation
___ Electrical Shock ___ Head Injury ___ Inflammation/Swelling ___ Loss of Consciousness
___ Spinal Injury ___ Suspected Bone Fracture/Break
___ Other: _____



DESCRIPTION OF TREATMENT

First Aid Provided By: _____

Time of Aid: _____

Initial Treatment:

___ No Treatment Required
___ Band Aid ___ CPR ___ Crutches ___ Ice ___ Sling/Splint

Additional Details:

FOLLOW-UP ACTION

___ None
___ Ambulance ___ Hospital/Clinic ___ Medical Practitioner/On-Site Trainer ___ Parent Call
___ Other: _____

Supervising Staff: _____ Signature: _____

Date: _____

Witness: _____ Signature: _____

Date: _____

Signature Of Person Completing Form: _____

Date: _____