



This report reflects 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  
 Overbalance  Overstretch  Slip/Trip  Fall /Awkward Landing

Nature of injury:  New  Recurring  Aggravated  Other: \_\_\_\_\_

Area injured:

Symptoms:  Blisters  Bleeding Nose  Cut  Burn  Cramp  
 Bruising  Dislocation  Spinal Injury  Cardiac Problem  
 Suspected Bone Fracture/Break  Inflammation/Swelling  Electrical Shock

DESCRIPTION OF TREATMENT

First Aid Provided By: \_\_\_\_\_

Time of Aid: \_\_\_\_\_

Initial Treatment:  No Treatment Required

Ice  Band Aid

Crutches

Sling/Splint  CPR



**Additional Details:**

FOLLOW-UP ACTION

None                       Medical Practitioner/On-Site Trainer                       Parent Call  
 Hospital/Clinic                       Ambulance                       Other: \_\_\_\_\_

**Supervising Staff:** \_\_\_\_\_                      **Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Witness:** \_\_\_\_\_                      **Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Signature Of Person Completing Form:** \_\_\_\_\_

**Date:** \_\_\_\_\_