CONFIDENTIAL
(For District Use Only)

Columbus City Schools - Student Accident Report

Note: The school employee either witnessing the accident or supervising at the time should complete and submit this form within 24 hours. IN CASE OF SERIOUS INJURIES, A TELEPHONE REPORT MUST BE MADE TO HEALTH SERVICES AT 365-5824.

1. School____

2. Pupil's Name_____________________________Age_______Grade________

   Address______________________________City__________State________

   Phone Number(s)____

3. Date of Accident__________ Time of Accident__________ AM PM

4. Specific Location of Accident______________________________________

5. Please give a complete description of the accident (Use the back of form if more space is needed)

   ____

   ____

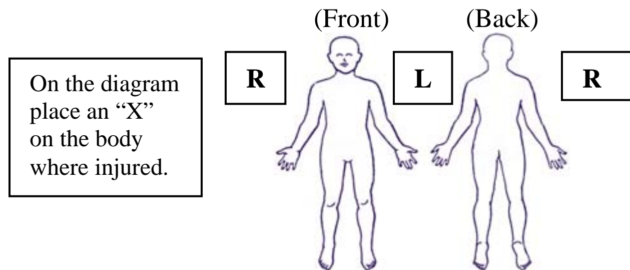
6. Witness name______________________________Phone__________________

   Address______________________________City__________State________

   Witness name______________________________Phone__________________

   Address______________________________City__________State________

7. Was there a visible injury? Yes No (If yes, indicate apparent nature of injury)
   Abrasion Cut Possible broken bone/dislocation
   Bruise Head Injury Teeth (broken)
   Other (explain)____



8. Was first aid administered? YES NO
9. Was the student seen by the school nurse? YES NO
9. Was EMS (911) called? YES NO
10. Was the parent/guardian notified? YES NO
    If unable to notify parent/guardian, who was notified? please explain____________________
    ____
11. Was the student seen by a physician? YES NO
12. Date student returned to school? __________
13 Additional comments: ____
    ____

Prepared by: (please print)______________________________ Title:________________
Signature:____ Date:________________

Principal's Signature:___________________________________ Date:________________

Please make three copies of this report:
Send original to Health Services Office
One copy is kept by the building Principal

09-2010