SIDNEY CENTRAL SCHOOLS
STUDENT ACCIDENT REPORT

NAME: _____ DOB: _____

ADDRESS: _____ SEX M / F GRADE: _____

DATE OF ACCIDENT: _____ SITE OF ACCIDENT:_____

TIME OF INCIDENT: _____ AM / PM Interscholastic? Before School? School Day? After School?

PARENTAL RELATION: _____ PHONE: _____

TYPE OF INJURY (Please circle)	**BODY PART INJURED** (Please circle)	**DESCRIPTION OF ACCIDENT** (Full description of event and injury)
Abrasion	Abdomen	
Bruise	Ankle / Foot / Leg / Knee	
Bump	Arm / Elbow / Hand / Wrist	
Burn	Back	
Concussion	Chest	
Cut / Laceration	Ear	
Crush / Pinch	Eye	
Dislocation	Face / Nose / Chin	
Fracture / Break	Finger	
Hernia	Groin / Pelvis / Hip	
Overexertion	Head / Scalp	
Poison	Neck	
Puncture	Shoulder	
Sprain / Strain	Teeth / Mouth	
Shock / Trauma	Other:	
Other:		

FIRST AID RENDERED BY: _____ ACTION TAKEN: _____

Adult in charge at time of accident: _____

Who was notified? _____ By Whom? _____

Was injured transported anywhere? Y / N Location of transport: _____

By whom? _____ When? _____

Witness: _____ Witness: _____

Person completing form: _____ Date: _____

School Nurse: _____ Date: _____

Administrator: _____ Date: _____

Kf 8/27/09

White: Nurse Yellow: Coach Pink: Athletic Director