Ohio Hi-Point Joint Vocational School District

ACCIDENT REPORT
STUDENT / VISITOR

NAME _____ ◯ Staff ◯ Student ◯ Visitor

First Middle Last

DATE AND TIME OF ACCIDENT _____ ◯ A.M. ◯ P.M.

Supervised activity? ◯ Yes ◯ No If yes, person in charge _____

ACCIDENT DESCRIPTION: Please describe what happened completely so that this report may be used to prevent other similar accidents.

_____

Signature

If supervised, report of person in charge

_____

Signature

NATURE OF INJURY (May be completed after medical examination)

- ☐ 1. Abrasion
- ☐ 2. Bruise
- ☐ 3. Burn
- ☐ 4. Concussion
- ☐ 5. Cut
- ☐ 6. Dislocation
- ☐ 7. Fracture
- ☐ 8. Laceration
- ☐ 9. Puncture
- ☐ 10. Sprain
- ☐ 11. Strain
- ☐ 12. Other

PART OF BODY INJURED

I. HEAD
- ☐ 1. Scalp
- ☐ 2. Back
- ☐ 3. Front
- ☐ 4. Eyes
- ☐ 5. Ear
- ☐ 6. Nose
- ☐ 7. Mouth
- ☐ 8. Tooth
- ☐ 9. Neck

II. TRUNK
- ☐ 1. Chest
- ☐ 2. Abdomen
- ☐ 3. Back

III. ARMS
- ☐ 1. Shoulder
- ☐ 2. Upper arm
- ☐ 3. Elbow
- ☐ 4. Lower arm
- ☐ 5. Hand
- ☐ 6. Fingers

IV. LEGS
- ☐ 1. Hips
- ☐ 2. Upper leg
- ☐ 3. Knee
- ☐ 4. Lower leg
- ☐ 5. Foot
- ☐ 6. Toes

KIND OF ACCIDENT (check one only)
- ☐ 1. Animal bite or insect bite
- ☐ 2. Collision w/student (bump, etc.)
- ☐ 3. Contact w/hot or toxic substance
- ☐ 4. Fall or slip
- ☐ 5. Fighting
- ☐ 6. Struck by auto, bike, etc.
- ☐ 7. Struck by object (swing, etc.)
- ☐ 8. Student collided w/object (door, etc.)
- ☐ 9. Other

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ACCIDENT REPORT
STUDENT / VISITOR

WHERE ACCIDENT HAPPENED:

- ☐ Cafeteria
- ☐ Campus Grounds
- ☐ Classroom
- ☐ Hallway
- ☐ Job Site
- ☐ Kitchen/Restaurant
- ☐ Restroom
- ☐ School Bus
- ☐ Parking Lot
- ☐ Vocational Lab
- ☐ Other _____

POST ACCIDENT INFORMATION

A. Was first aid given? ◯ Yes ◯ No By whom? _____

B. Was parent or other responsible person notified? ◯ Yes ◯ No
By whom? _____ Time _____

C. Does health record indicate tetanus immunization currently effective? ◯ Yes ◯ No
If no, was parent/student advised to contact a physician? ◯ Yes ◯ No

D. Was injured sent home? ◯ Yes ◯ No If yes, was he/she accompanied? ◯ Yes ◯ No

E. Was injured sent to physician? ◯ Yes ◯ No
Name of physician _____

F. Was injured sent to hospital emergency room? ◯ Yes ◯ No

Name of hospital kdsjfljf s

Who accompanied injured asjkfl dsjkf

G. Days absent from school or work f0wip ljwl;f jksf

H. Workman's Compensation form filed? ◯ Yes ◯ No

Signed jfkldsjfls;d kj Title jkldsjfls ;dakjf

Teacher/Supervisor jksdlf jskald f

Other Witnesses jldk fjdklsf

(Attach statement from witnesses)

ACTION TAKEN TO PREVENT SIMILAR ACCIDENT

I. INSTRUCTIONAL

- ☐ 1. Discussed at staff meeting
- ☐ 2. Discussed in each class/part of regular instruction
- ☐ 3. Discussed with parent
- ☐ 4. Personal instruction given to injured
- ☐ 5. Personal instruction given to person in charge
- ☐ 6. Presented as a subject of assembly

II. PERSONS ADVISED OF INCIDENT

- ☐ 1. Director _____
- ☐ 2. Supervisor _____
- ☐ 3. Student Safety Rep _____
- ☐ 4. Other _____

THIS REPORT MUST BE FILED WITHIN 24 HOURS OF THE ACCIDENT

Adapted from:
Ohio Department of Health, Accident Prevention Unit
4966.32 Rev. 8/73 Revised 9/93