TO BE COMPLETED IMMEDIATELY	***ACCIDENT REPORT***
The school employee who either witnesses the injury or is supervising at the time of the injury should complete this form, if possible. The report should be submitted immediately to the Principal's office and then to the District Office for processing. Should other pertinent facts develop, notify the principal's office by means of a supplemental report. Please report only on the facts of the incident.	_____ School District

School Site	School Site Contact Person
School Site Address	School Site Phone Number
Injured Parties Name	Age Grade
Home Address	Home Phone Number
Where Did Incident Occur?	
Date of Incident	Time of Incident

How Did Incident Occur?

Employee in Charge of Injured Party at the Time of the Incident?	Was the Employee Present at the Time of the Incident? ___ Yes ___ No
Was a School Rule Violated? ___ Yes ___ No	

If Yes, Explain

Nature of the Injury	Disabled? ___ Yes ___ No
First Aid Applied? ___ Yes ___ No	By Whom?

Disposition of the Injured Party (return to class, sent home, doctor visit, hospital)

Did the Injured Party Waive the Volunteer Accident Insurance Coverage? ___ Yes ___ No
If No, Name of Insurance Company and Policy Number

Have the Parent/Guardian Contacted the School? ___ Yes ___ No
If Yes, What was their Attitude?

WITNESSES (Please list names and phone numbers of individuals who witnessed the incident)

COMMENTS

Report Submitted By	
Position	Date

THIS IS INTENDED TO BE AN INTERNAL REPORT OF ACCIDENT INFORMATION