STUDENT ACCIDENT/INCIDENT REPORT

Risk Co-Op for SW Washington Schools
(360) 750-7504

SCHOOL INFORMATION

District:_____ School:_____ Building:_____

Teacher (Home Room):_____ School Telephone #: _____

STUDENT INFORMATION

Student's Full Name:_____ Date of Birth:_____ Age:____ Grade: _____

Parents / Guardian Name:_____ Telephone #: _____

INJURY INFORMATION

Date of Injury:_____ Time:_____ AM_____ PM_____

Specific Nature of Injury: (Body Part): _____

Description of Accident: (What was student doing? List conditions at time of injury. Specify if tool, machine or equipment being used) _____

Person in Charge:_____ Title:_____ Present at Scene: Yes_____ No _____

Did person completing this form witness the accident? Yes_____ No_____ If no, how did they become aware? _____

Specific Location of Accident: (Playground east side of slide, In hall outside room #, etc.)_____

Witnesses: (List name & telephone number - Attach separate sheet if necessary)

(1) _____

(2) _____

ACTION TAKEN

Type of First Aid Treatment Given: _____

Given by:_____ Student Sent Home? Yes ____ No _____ , If so, by whom: _____

School Nurse, if involved:_____ EMT's, if involved: _____

Sent to Doctor: Yes____ No_____ By Whom: _____ Doctor:_____

Sent to Hospital: Yes____ No_____ By Whom: _____ Hospital: _____

Was parent/guardian or other individual notified? Yes ____ No____ Who:_____ Relationship:_____

How Notified:_____ Date_____ Time:_____ AM_____ PM _____

If head injury, was parent given a head Injury letter? Yes_____ No____ If yes, date sent/given:_____

FOLLOW-UP

Status of Student after Incident: _____

Problem Corrected: Yes:____ No:_____ Specific Actions Taken to Prevent Future Accidents: _____

_____ _____

Principal's Signature Person Observing or Reporting Accident

Risk Co-Op
YOUR TRUSTED PARTNER
FOR SW WASHINGTON SCHOOLS

Original to: ☐ ESD 112 Risk Co-Op Copies: ☐ District Office ☐ Student's File

CONFIDENTIAL RECORD RETAIN FOR 8 YEARS Form Rev. 10/6/22