# STUDENTS 09.224 AP.22

Accident Report

This form is to be completed by the appropriate employee(s) as soon as possible after an accident occurs. Please Print or Type.

LaRue County School District

School Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Principal’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Accident: \_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_ 🞏 am 🞏 pm Supervising Employee \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Student’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ***Last Name First Name Middle Initial***  Student’s Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ***City State ZIP Code***  Parent’s Name (if student) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone Number (\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ***Nature of Injury*** | |  | ***Place of Accident*** | |  | ***Body Part Injured*** | | |
| 🞏 Scratch | 🞏 Concussion |  | 🞏 Classroom | 🞏 Gymnasium |  | 🞏 Ankle | 🞏 Foot | 🞏 Leg |
| 🞏 Fracture | 🞏 Head Injury |  | 🞏 Hallway | 🞏 Parking Lot |  | 🞏 Arm | 🞏 Face | 🞏 Nose |
| 🞏 Bruise | 🞏 Sprain/Strain |  | 🞏 Bathroom | 🞏 Sidewalk |  | 🞏 Back | 🞏 Finger | 🞏 Teeth |
| 🞏 Burn | 🞏 Cut/Puncture |  | 🞏 Cafeteria | 🞏 Stairs |  | 🞏 Neck | 🞏 Hand | 🞏 Wrist |
| 🞏 Dislocation | 🞏 Bite |  | 🞏 Playground | 🞏 Athletic Field |  | 🞏 Eye | 🞏 Knee | 🞏 Shoulder |
| 🞏 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  | 🞏 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  | 🞏 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

***Describe exactly how accident happened: (Attach additional sheets if necessary). \_\_\_\_\_\_\_\_\_\_\_\_\_***

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

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Were efforts made to contact the parent/guardian about the accident? 🞏 Yes 🞏 No

Was first aid administered? 🞏 Yes 🞏 No By whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was the student 🞏 Sent home 🞏 Sent to physician 🞏 Sent to hospital

***If medical or hospital treatment was required, please complete section II of the K & K Insurance forms and mail original to parent/s and send copies to the Central Office.***

Name of Witnesses \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***Signature/Name of Person Completing the Report Date***

***Forward completed form to Central Office: fax number 270-358-3053 or email to jane.matthews@larue.kyschools.us***

Review/Revised:7/21/14