INCIDENT REPORT

This report must be filled out within twenty-four (24) hours of the incident.

_____ _____ _____ ☐ a.m. _____ ☐ MALE _____
SCHOOL AND/OR LOCATION OF INCIDENT DATE OF INCIDENT TIME OF INCIDENT ☐ p.m. NAME OF PERSON INVOLVED ☐ FEMALE AGE

PERSON INVOLVED IS:

☐ **STUDENT** GRADE_____ H R TEACHER_____ PARENT/GUARDIAN NAME_____

HOME ADDRESS_____ HOME PHONE _____

WAS A SCHOOL STAFF PERSON PRESENT AT SCENE OF INCIDENT? YES_____ NO_____

☐ **RCBOE EMPLOYEE** JOB TITLE_____ HOME SCHOOL/DEPT_____ TIME IN THIS POSITION_____

HOME ADDRESS_____ HOME PHONE _____

☐ **VISITOR/VOLUNTEER** HOME ADDRESS_____ HOME PHONE _____

REASON FOR PRESENCE AT THIS SCHOOL/LOCATION_____

WERE THERE WITNESSES? YES ☐ NO ☐ If YES, GIVE NAME(S) TITLE, ADDRESS, PHONE NUMBER.

_____

_____

EQUIPMENT INVOLVED ☐ PROPERTY INVOLVED ☐ DESCRIBE: _____

_____

DESCRIBE EXACTLY WHAT CAUSED THE INCIDENT: WHAT HAPPENED, WHY IT HAPPENED: _____

_____

_____

DESCRIBE TYPE AND EXTENT OF ANY INJURY: _____

_____

_____

_____

_____

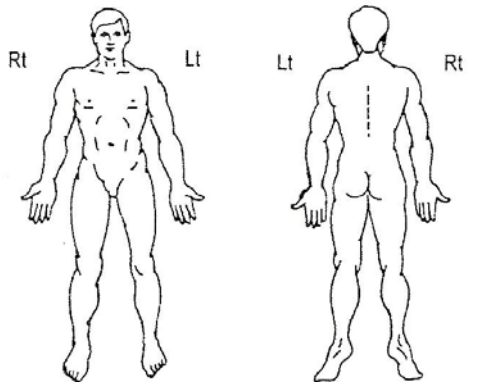
_____

_____

_____

_____

MARK AN "X" ON DIAGRAM TO SHOW LOCATION OF INJURY(IES)



LEVEL OF CONSCIOUSNESS OF INVOLVED PERSON:
Injured person was alert and oriented to time, place, person **before** the incident: YES ☐ NO ☐ **After** the incident: YES ☐ NO ☐ If no, please explain.

_____

_____

WHAT ACTION(S) WAS TAKEN IMMEDIATELY FOLLOWING THIS INCIDENT?

(A) WAS PERSON INVOLVED GIVEN FIRST AID: YES ☐ NO ☐ **SIGNATURE OF PERSON GIVING FIRST AID**_____

PERSON GIVING FIRST AID - DESCRIBE CARE GIVEN:_____

_____

_____

WAS PERSON INVOLVED:

(B) SENT TO DOCTOR YES ☐ NO ☐ BY WHOM?_____ NAME OF DOCTOR_____

(C) SENT TO HOSPITAL YES ☐ NO ☐ BY WHOM?_____ NAME OF HOSPITAL_____

(D) SENT BACK TO CLASS YES ☐ NO ☐ BY WHOM?_____

(E) OTHER - DESCRIBE:_____

_____

WAS FAMILY NOTIFIED? YES ☐ NO ☐ IF YES, WHO WAS NOTIFIED? GIVE NAME AND RELATIONSHIP TO PERSON INVOLVED:_____

DATE NOTIFIED_____ TIME NOTIFIED_____a.m./p.m. HOW NOTIFIED_____ WHO NOTIFIED PERSON_____

NAME AND TITLE/POSITION OF PERSON MAKING REPORT_____ **POSITION WITH RCBOE**_____

If you are an employee who has sustained an injury due to the incident described above, do you plan to seek medical treatment? YES ☐ NO ☐

EMPLOYEE SIGNATURE_____ DATE_____

SIGNATURE OF SCHOOL PRINCIPAL_____ **DATE REPORT COMPLETED**_____

INSTRUCTIONS: (1) SEND WHITE COPY TO DIRECTOR OF HEALTH SERVICES COUNTY OFFICE (2) YELLOW COPY - FOR SCHOOL FILES.