EMPLOYEE ACCIDENT REPORT

EMPLOYEE NAME:_____DATE OF ACCIDENT:_____TIME:_____

SCHOOL NAME:_____ LOCATION OF ACCIDENT:_____

DETAILED DESCRIPTION OF ACCIDENT: _____

_____

_____

_____

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_____

WITNESS (ES): _____

BODY PART INJURED:

HEAD:	TRUNK:	ARMS:	LEGS:
___ SCALP	___ CHEST	___ SHOULDER	___ UPPER LEG
___ FOREHEAD	___ ABDOMEN	___ UPPER ARM	___ LOWER LEG
___ EYE(S)	___ BACK	___ LOWER ARM	___ HIP
___ NOSE	___ NECK	___ ELBOW	___ KNEE
___ MOUTH	___ GROIN	___ FINGER(S)	___ ANKLE
___ CHEEK	___ GLUTEAL	___ WRIST/HAND	___ FOOT
___ EAR(S)	___ PUBIC AREA	___ PALM	___TOE(S)
___ CHIN			
___ TEETH			

TYPE OF INJURY SUSPECTED:

____ SCRATCH	____ FRACTURE	____ ABRASION/SCRAPED
____ LACERATION	___ DISLOCATION	___ DRUGS/ALCOHOL
____ WELT	____ SPRAIN/STRAIN	____ LOOSE TEETH/ BROKEN
____ HEMATOMA	___ BURN	___ CONCUSSION/ HEAD INJURY
____ BRUISE	____ PUNCTURE	___ EYE INJURY
____ BLOODY NOSE	____ BITE MARK	____ OTHER: _____

FIRST AID:

____ ICE	____ WASHED WOUND	____ KEPT IMMOBILE	____ PRESSURE APPLIED/ STOP BLEEDING
____ SPLINT/SLING	____ REST	____ OBSERVATION	
____ DRESSING	___ LOC/GLASCOW	____ PERRL	____ OTHER_____
____ VITAL SIGNS	____ MEDICATION	____ EYE WASH	

TREATMENT OR MEDICATION GIVEN:_____

_____

ADMINISTRATOR SIGNATURE_____ HA/NURSE SIGNATURE_____

DISTRICT NOTIFIED ☐ YES ☐ NO BY WHOM _____ WHEN/HOW _____

NURSE TRIAGE LINE CALLED? ☐ YES ☐ NO HOME CARE ADVISED? ☐ YES ☐ NO

FOLLOW-UP_____