INCIDENT REPORT FORM

AKRON CENTRAL SCHOOL DISTRICT

[ ] **Serious** - injury involving physician/hospital

If Student - Nurse to complete and mail Student Insurance Claim Form to Parent/Guardian

Name of Person Injured _____

Address: _____

Telephone #: _____

[ ] Akron Student [ ] Akron Employee [ ] Visitor/Other

Incident Date: ____/____/____ Incident Time: _____AM /PM Person Making Report_____

Describe Incident and Injury:

_____

_____

SAMPLE

Describe How and Where Incident Occurred _____

_____

_____

Witnesses: Name _____ Telephone #: _____

First Aid Given/By Whom: _____

Did injured require medical attention from physician or hospital? [ ] Yes [ ] No [ ] Do Not Know

Was Injured Transported? [ ] None [ ] ER/Hospital [ ] Home [ ] Doctor

By Whom_____

If Employee, time lost from work? [ ] Yes [ ] No [ ] Do Not Know

Signatures:

Person Making Report _____ Date: ____/____/____

Email _____ Telephone: _____

White Copy – Cindy Tretter

Yellow Copy - Building Principal or Athletic Director or Supervisor

Pink Copy - School Nurse

USE ADDITIONAL SHEETS IF NEEDED