

WAKE COUNTY PUBLIC SCHOOL SYSTEM
Risk Management Department
STUDENT/VISITOR ACCIDENT REPORT FORM

I. To be completed by School Administrator, Supervising Teacher or other employee.

Name of injured person: _____ Age: _____ Grade: _____

School Name: _____ Date of injury: _____ Time: _____

Room or location where injury occurred: _____ Part(s) of body injured: _____

Nature of injury: Laceration/Abrasion Fracture Sprain/Strain Burn
 Amputation Electrical Shock Puncture Bruise/Contusion Concussion
 Dislocation Other: _____

Description of the accident (Specifically): How did it happen? What was the student or visitor doing?
Why did the accident occur? _____

Specify any tool or equipment involved. _____

Corrective Action to prevent same type accident: _____

List any witnesses and/or participants: _____

FILLED OUT BY: _____ Date: _____

ADMINISTRATOR, TEACHER, &/OR OTHER EMPLOYEE SIGNATURE: _____

II. To be completed by person giving treatment or assistance.

Immediate action taken: First aid treatment (Ice, Washed wound, Kept immobile, Observed, Stopped bleeding, Applied splint, Applied dressing). Released to Parent Called 911
 Parent or self took to Physician/ER

Name of physician: _____ Sent to hospital/Urgent Care: Yes No

Name of hospital/Urgent Care: _____ Other: _____

Individual Notified Name (parent/guardian/other): _____

Individual Notified above (telephone number): _____

Time and method of notification/attempt(s) to notify: _____

Remarks and recommendations: _____

FILLED OUT BY: _____ Date: _____