WAKE COUNTY
PUBLIC SCHOOL SYSTEM

1. Section to be completed by School Administrator, Supervising Teacher or other employee.

Injured Person

Last Name:	First Name:	Date of Injury:	Time:
School Name:		Grade:	Age:
Before/After Program:		Room or location where injury occurred:	

Parts of body injured:
Nature of injury: ☐ Laceration ☐ Fracture ☐ Sprain/Strain ☐ Burn ☐ Amputation ☐ Electrical Shock ☐ Puncture ☐ Bruise/Contusion ☐ Dislocation ☐ Head Injury ☐ Other / Describe Head Injury or Other:
Description of accident (how, what, why?):
Specify tool or equipment involved:
Corrective Action to prevent the same type of accident:
Witnesses or participants:

Form completed by:	Date:

WCPSS Employee Signature:____

2. Section 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 or Urgent Care: ☐ Yes ☐ No
Name of Hospital or Urgent Care:	Other:

Individual Notified (Parent / Guardian / Other)

Name:	Phone #:
Time and method of notification or attempt to notify:	Remarks:
Form completed by:	Date:

Email one (1) copy of this report to Risk Management: rm-accident-reports@wcpss.net
Retain one (1) copy for your file.