

INJURY REPORT

EVERETT PUBLIC SCHOOLS • RISK & COMPLIANCE SERVICES • COMMUNITY RESOURCE CENTER STUDENT/VOLUNTEER/CITIZEN ~ INCIDENT/ACCIDENT REPORT FORM

THIS FORM DOES **NOT** COMPLY WITH RCW 4.96.020 FOR THE FILING OF A CLAIM FOR DAMAGES

FORM INSTRUCTIONS: This form to be completed by **DISTRICT PERSONNEL ONLY** any time a student or person other than an employee is injured on Everett Public Schools property. *Do not allow student or parents/injured party to complete. Do not use this form to report employee (on the job) injuries (Contact Benefits at 425-385-4115).* Complete and email this form to Risk & Compliance Services at InjuryReports@everettsd.org within 24 hours of the incident. **If an accident occurs that is critical in nature, please call Risk & Compliance Services at 425-385-4153 and report the accident verbally in addition to emailing the form. Describe the incident below in sufficient detail to show the conditions that existed at the time of the incident.**

GENERAL INFORMATION		SCHOOL DISTRICT: Everett Public Schools	SCHOOL NAME:
DISTRICT CONTACT: Brenna Hanson			PHONE NUMBER: 425-385-4153
INCIDENT/ACCIDENT DATE:		TIME:	
LOCATION: <input type="checkbox"/> CLASSROOM <input type="checkbox"/> PLAYGROUND <input type="checkbox"/> GYM <input type="checkbox"/> LABORATORY <input type="checkbox"/> SHOP <input type="checkbox"/> OFF-PREMISES <input type="checkbox"/> OTHER, SPECIFY:			
DESCRIBE CAUSE OF ACCIDENT OR INJURY:			
WITNESS(ES):		PHONE NUMBER:	
WITNESS(ES):		PHONE NUMBER:	
IDENTIFY AGENCY CALLED TO SCENE (police, fire, etc):		REPORT NUMBER:	

INJURIES (complete separate form for each injured individual)		FOR EMPLOYEE INJURIES – CONTACT HUMAN RESOURCES AT 425-385-4115	
NAME:		<input type="checkbox"/> STUDENT <input type="checkbox"/> CITIZEN	
LAST	FIRST	MI	
ADDRESS:		GENDER:	AGE: GRADE:
STREET		CITY	ZIP CODE
NAME OF PARENT/GUARDIAN (if applicable):		HOME PHONE:	
ADDRESS OF PARENT:		WORK PHONE:	
PART OF BODY INJURED:		TYPE OF INJURY (e.g., cut, burn):	
EXTENT OF INJURY (e.g., minor, severe):		NO. OF SCHOOL DAYS LOST:	
IF CITIZEN, REASON FOR BEING AT SCHOOL/FACILITY:			
PERSON IN CHARGE AT TIME OF INCIDENT:		TITLE:	PHONE #:
ACTION TAKEN:			
BY WHOM/WHEN:		PRESENT AT SCENE? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<input type="checkbox"/> SENT TO HEALTH ROOM <input type="checkbox"/> SENT HOME <input type="checkbox"/> 911 CALLED <input type="checkbox"/> SENT TO HOSPITAL/DOCTOR		IF STUDENT, ACCIDENT. INS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<input type="checkbox"/> STUDENT FELT WELL AND RETURNED TO CLASS AFTER _____ MINUTES OF OBSERVATION			

ADDITIONAL INJURY INFORMATION:	
PARENT/GUARDIAN NOTIFIED:	PHONE #:
WHEN NOTIFIED:	BY WHOM:

BUMPS OR BLOWS TO THE HEAD - SYMPTOMS:			
<input type="checkbox"/> SLIGHT HEADACHE	<input type="checkbox"/> MINOR ABRASION/CUT	<input type="checkbox"/> PALENESS OR FLUSHING	<input type="checkbox"/> WEAKNESS OR PARALYSIS
<input type="checkbox"/> NAUSEA/VOMITING	<input type="checkbox"/> CONFUSION/INCOHERENT	<input type="checkbox"/> BRUISING/SORE	<input type="checkbox"/> LOSS OF CONSCIOUSNESS
<input type="checkbox"/> LOSS OF MEMORY	<input type="checkbox"/> DIZZINESS	<input type="checkbox"/> VISION CHANGES	<input type="checkbox"/> SWELLING AT INJURY SITE

BUMPS OR BLOWS TO THE HEAD - TREATMENT:	
<input type="checkbox"/> ICE APPLIED <input type="checkbox"/> BANDAGE APPLIED <input type="checkbox"/> OTHER (comment):	

REPORT PREPARED BY: _____ TITLE: _____

SIGNATURE: _____ DATE: _____

BLDG. ADMINISTRATOR SIGNATURE: _____ DATE: _____