INJURY REPORT

EVERETT PUBLIC SCHOOLS • GENERAL COUNSEL• 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 Human Resources at 425-385-4115). Complete and forward this form to General Counsel, Risk Manager within 24 hours of the incident. **If an accident occurs that is critical in nature, please call General Counsel, Risk Manager at 425-385-4153 and report the accident verbally. Describe the incident 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: AM

LOCATION: ☐ CLASSROOM ☐ PLAYGROUND ☐ GYM ☐ LABORATORY ☐ SHOP ☐ OFF-PREMISES ☐ 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: ☐ STUDENT ☐ CITIZEN

LAST FIRST MI

ADDRESS: GENDER: Male AGE: GRADE: K

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)*:	CELL PHONE:

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? ☐ YES ☐ NO

☐ SENT TO HEALTH ROOM ☐ SENT HOME ☐ 911 CALLED ☐ SENT TO HOSPITAL/DOCTOR IF STUDENT, ACCIDENT. INS? ☐ YES ☐ NO

☐ 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:

☐ SLIGHT HEADACHE	☐ MINOR ABRASION/CUT	☐ PALENESS OR FLUSHING	☐ WEAKNESS OR PARALYSIS
☐ NAUSEA/VOMITING	☐ CONFUSION/INCOHERENT	☐ BRUISING/SORE	☐ LOSS OF CONSCIOUSNESS
☐ LOSS OF MEMORY	☐ DIZZINESS	☐ VISION CHANGES	☐ SWELLING AT INJURY SITE

BUMPS OR BLOWS TO THE HEAD - TREATMENT:

☐ ICE APPLIED ☐ BANDAGE APPLIED ☐ OTHER *(comment)*:

REPORT PREPARED BY: _____ TITLE: _____

SIGNATURE: _____ DATE: _____

BLDG. ADMINISTRATOR SIGNATURE: _____ DATE: _____