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 Benefits at 425-385-4115). Complete and *email* this form to General Counsel, **InjuryReports@everettsd.org** within 24 hours of the incident. **If an accident occurs that is critical in nature, please call General Counsel, Risk Management, 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: 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: 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)*:	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: _____