

**ACCIDENT REPORT**  
**Transylvania County Schools**

*THE INJURED PARTY OR SCHOOL REPRESENTATIVE SHOULD FILL OUT THIS FORM*

Name: \_\_\_\_\_ Injured party (Student or Visitor): \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Sex (M or F): \_\_\_\_\_ Age: \_\_\_\_\_  
 Date and time accident occurred: \_\_\_\_\_  
 Room or area where accident occurred: \_\_\_\_\_

Description of accident: Please describe how the accident happened. What was the injured party doing? List any specific acts by individuals or conditions that led to the accident. (include any tools, machinery or instrument involved)

Description of action taken by school personnel:

Nature of Injury (X)			Part of Body Injured (X)		
<input type="checkbox"/> Abrasion	<input type="checkbox"/> Cut	<input type="checkbox"/> Scratch	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Face	<input type="checkbox"/> Leg
<input type="checkbox"/> Amputation	<input type="checkbox"/> Dislocation	<input type="checkbox"/> Shock	<input type="checkbox"/> Ankle	<input type="checkbox"/> Finger	<input type="checkbox"/> Mouth
<input type="checkbox"/> Asphyxiation	<input type="checkbox"/> Fracture	<input type="checkbox"/> Sprain	<input type="checkbox"/> Back	<input type="checkbox"/> Foot	<input type="checkbox"/> Nose
<input type="checkbox"/> Bite	<input type="checkbox"/> Laceration	<input type="checkbox"/> Splinter	<input type="checkbox"/> Chest	<input type="checkbox"/> Forearm	<input type="checkbox"/> Shoulder
<input type="checkbox"/> Bruise	<input type="checkbox"/> Poisoning	<input type="checkbox"/> Strain	<input type="checkbox"/> Ear	<input type="checkbox"/> Hand	<input type="checkbox"/> Teeth
<input type="checkbox"/> Burn	<input type="checkbox"/> Puncture		<input type="checkbox"/> Elbow	<input type="checkbox"/> Head	<input type="checkbox"/> Wrist
<input type="checkbox"/> Concussion	<input type="checkbox"/> Repetitive Stress Injury		<input type="checkbox"/> Eye	<input type="checkbox"/> Knee	
<input type="checkbox"/> Other (specify) _____			<input type="checkbox"/> Other (specify) _____		

Is video evidence available (Y or N)? \_\_\_\_\_  
 Were parents/responsible party notified (Y or N)? \_\_\_\_\_  
 Was school nurse notified (Y or N)? \_\_\_\_\_  
 Was first aid administered by school personnel (Y or N)? \_\_\_\_\_

Description of treatment administered by school personnel:

Was injured party transported to the hospital or doctor for treatment (Y or N)?

\_\_\_\_\_  
 School Representative Date