

# Woodridge Local School District

## INCIDENT/ACCIDENT REPORT

School \_\_\_\_\_

### Information of Student Involved in Incident

Name of Student _____		
Last	First	Middle Initial
Address _____		
_____		
Age _____	Grade _____	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female

Incident/Accident Information: Date of Incident _____	Time of incident _____ A.M. _____ P.M.
Supervised Activity? <input type="checkbox"/> No <input type="checkbox"/> Yes	Name of Person in charge _____

### Where Did Incident/Accident Occur (Check Only One)

<input type="checkbox"/> Athletic Field	<input type="checkbox"/> Hallway	<input type="checkbox"/> Stairway
<input type="checkbox"/> Cafeteria	<input type="checkbox"/> Playground	<input type="checkbox"/> To and From School
<input type="checkbox"/> Classroom	<input type="checkbox"/> Restroom	<input type="checkbox"/> Vocational Shop/Lab
<input type="checkbox"/> Gym	<input type="checkbox"/> School Bus	<input type="checkbox"/> Other

### Kind of Incident/Accident

<input type="checkbox"/> Animal Bite	<input type="checkbox"/> Fight	<input type="checkbox"/> Contact with Hot or Toxic Substance
<input type="checkbox"/> Fall or Slip	<input type="checkbox"/> Struck by Object	<input type="checkbox"/> Other
<input type="checkbox"/> Struck by Car/Bike	<input type="checkbox"/> Collision with Student	
<input type="checkbox"/> Inspect Bite	<input type="checkbox"/> Collision with object (door, etc.)	

### Nature of Injury

<input type="checkbox"/> Abrasion	<input type="checkbox"/> Concussion	<input type="checkbox"/> Fracture	<input type="checkbox"/> Sprain
<input type="checkbox"/> Bruise	<input type="checkbox"/> Cut	<input type="checkbox"/> Laceration	<input type="checkbox"/> Strain
<input type="checkbox"/> Burn	<input type="checkbox"/> Dislocation	<input type="checkbox"/> Puncture	<input type="checkbox"/> Other

### PARTS OF BODY INJURED

HEAD	TRUNK	ARMS	LEGS
<input type="checkbox"/> Scalp	<input type="checkbox"/> Chest	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Hip
<input type="checkbox"/> Eye(s)	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Upper Arm	<input type="checkbox"/> Upper Leg
<input type="checkbox"/> Ear(s)	<input type="checkbox"/> Back	<input type="checkbox"/> Elbow	<input type="checkbox"/> Knee
<input type="checkbox"/> Nose	<input type="checkbox"/>	<input type="checkbox"/> Lower Arm	<input type="checkbox"/> Lower Leg
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hand	<input type="checkbox"/> Foot
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Fingers	<input type="checkbox"/> Toe(s)

### CONTRIBUTING CAUSES

Environmental Factors	Human Factors	Agents
<input type="checkbox"/> Crowding	<input type="checkbox"/> Active Game	<input type="checkbox"/> Animal <input type="checkbox"/> Insect
<input type="checkbox"/> Door	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Electricity
<input type="checkbox"/> Drinking Fountain	<input type="checkbox"/> Fighting	<input type="checkbox"/> Fire <input type="checkbox"/> Gas <input type="checkbox"/> Liquid
<input type="checkbox"/> Equipment	<input type="checkbox"/> Horseplay	<input type="checkbox"/> Recreation Equipment
<input type="checkbox"/> Floors	<input type="checkbox"/> Lack of Training/Experience	<input type="checkbox"/> Pencil
<input type="checkbox"/> Hard Surfaces	<input type="checkbox"/> Preoccupation	<input type="checkbox"/> School Equipment
<input type="checkbox"/> Lighting	<input type="checkbox"/> Running	<input type="checkbox"/> Student
<input type="checkbox"/> No Handrail	<input type="checkbox"/> Violation of Rules	<input type="checkbox"/> Vehicle
<input type="checkbox"/> Weather	<input type="checkbox"/> Other	<input type="checkbox"/> Other

**INCIDENT/ACCIDENT DESCRIPTION**

Describe the accident in your own words. Please give all details so that this accident report may be used to prevent other similar accidents.


**POST ACCIDENT INFORMATION**

**Was first aid given:**    Yes                       No                       **By whom** \_\_\_\_\_

Parent/responsible adult notified \_\_\_\_\_ By whom \_\_\_\_\_

If not, explain \_\_\_\_\_

Date of last immunization \_\_\_\_\_

Injured sent home? \_\_\_\_\_ Yes  \_\_\_\_\_ No  \_\_\_\_\_ Accompanied by \_\_\_\_\_

Injured sent to physician?                      Yes                       No                       Physician's Name \_\_\_\_\_

Injured sent to emergency room?            Yes                       No                       Hospital's Name \_\_\_\_\_

Days absent from work/school \_\_\_\_\_

**ACTION TAKEN TO PREVENT SIMILAR ACCIDENT**

<b>INSTRUCTIONAL</b>	<b>POLICY OR CORRECTIVE ACTION</b>
<input type="checkbox"/> Discussed at staff meeting <input type="checkbox"/> Discussed in each class as part of regular instruction <input type="checkbox"/> Discussed with parent <input type="checkbox"/> Personal instruction given to injured <input type="checkbox"/> Personal instruction given to person in charge <input type="checkbox"/> Presented as a subject of assembly program <input type="checkbox"/> No action taken <input type="checkbox"/>	<input type="checkbox"/> Environmental changes affected <input type="checkbox"/> Notified school safety committee <input type="checkbox"/> Safety rules amended to prevent reoccurrence <input type="checkbox"/> Safety specialist invited to school to assist in safety program <input type="checkbox"/> Suggest closer supervision <input type="checkbox"/> Forward to Superintendent for further review <input type="checkbox"/>

Signed \_\_\_\_\_ Title \_\_\_\_\_

Teacher \_\_\_\_\_

Other Witnesses \_\_\_\_\_

Principal \_\_\_\_\_

- 9/1/01
- 9/02
- 10/02
- 10/06