

## Jessamine County Schools - Student Injury Report

**Supervising employee: Complete form immediately following accident. Send copies to: Pat Glass, R.N., 851 Wilmore Road, fax 859-887-4993, school nurse.**

*This form is for internal use only. Do not give to parent/guardian.*

School \_\_\_\_\_ School Phone \_\_\_\_\_

**Date of Accident:** \_\_\_\_\_ **Time:** \_\_\_\_\_ AM  PM **Supervising Employee** \_\_\_\_\_

Student's Name \_\_\_\_\_  
*Last Name* *First Name* *MI*

Student's Age \_\_\_\_\_ Sex \_\_\_\_\_ Grade \_\_\_\_\_ Homeroom \_\_\_\_\_

<i>Nature of Injury</i>		<i>Place of Accident</i>		<i>Body Part Injured</i>		
<input type="checkbox"/> Scratch	<input type="checkbox"/> Concussion	<input type="checkbox"/> Classroom	<input type="checkbox"/> Gymnasium	<input type="checkbox"/> Ankle R / L	<input type="checkbox"/> Foot R / L	<input type="checkbox"/> Leg R / L
<input type="checkbox"/> Fracture	<input type="checkbox"/> Head Injury	<input type="checkbox"/> Hallway	<input type="checkbox"/> Parking Lot	<input type="checkbox"/> Arm R / L	<input type="checkbox"/> Face	<input type="checkbox"/> Nose
<input type="checkbox"/> Bruise	<input type="checkbox"/> Sprain/Strain	<input type="checkbox"/> Bathroom	<input type="checkbox"/> Sidewalk	<input type="checkbox"/> Back	<input type="checkbox"/> Finger	<input type="checkbox"/> Teeth
<input type="checkbox"/> Burn	<input type="checkbox"/> Cut/Puncture	<input type="checkbox"/> Cafeteria	<input type="checkbox"/> Stairs	<input type="checkbox"/> Neck	<input type="checkbox"/> Hand R / L	<input type="checkbox"/> Wrist R / L
<input type="checkbox"/> Dislocation	<input type="checkbox"/> Bite	<input type="checkbox"/> Playground	<input type="checkbox"/> Athletic Field	<input type="checkbox"/> Eye R / L	<input type="checkbox"/> Knee R / L	<input type="checkbox"/> Shoulder R / L
<input type="checkbox"/> Other		<input type="checkbox"/> Other		<input type="checkbox"/> Other		

**Describe accident and injury in detail:** *(Attach additional description as necessary or use back of form)*

\_\_\_\_\_

\_\_\_\_\_

Was parent/guardian contacted about the accident?  Yes  No By Whom \_\_\_\_\_

Was first aid administered?  Yes  No By Whom? \_\_\_\_\_

Describe first aid given: \_\_\_\_\_

Was the student  Sent home  Sent to physician  Sent to hospital  No action needed

*If medical or hospital treatment was required or advised, please complete the following information and then fill out a Student Insurance form, give one copy to parent and send copy attached to this form to Pat Glass.  
 [Remember, do not give copy of injury report to parents]*

Name and address of doctor or hospital \_\_\_\_\_

Witnesses (Name, Address & Phone) \_\_\_\_\_

\_\_\_\_\_

Principal Signature \_\_\_\_\_ Date \_\_\_\_\_ Person completing this report \_\_\_\_\_ Date \_\_\_\_\_

**NOTE: THIS FORM MUST REMAIN ON FILE IN THE SCHOOL AND THE SCHOOL NURSES'S OFFICE FOR AT LEAST 3 YEARS.** Student Accident Form 2014

THIS REPORT IS FOR INTERNAL USE ONLY, DO NOT GIVE TO PARENT.