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*without approval from CRMA*

**University High School** School District

## STUDENT INCIDENT REPORT

1. STUDENT \_\_\_\_\_

2. ADDRESS \_\_\_\_\_

SS# \_\_\_\_\_ TEL \_\_\_\_\_

3. GRADE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

4. PARENTS \_\_\_\_\_

5. SCHOOL \_\_\_\_\_

6. CONTACT \_\_\_\_\_ TEL \_\_\_\_\_

7. DATE INJURED \_\_\_\_\_ TIME \_\_\_\_\_ AM/PM

8. WITNESSES:

a. \_\_\_\_\_ TEL \_\_\_\_\_

b. \_\_\_\_\_ TEL \_\_\_\_\_

9. WAS THE INJURY FATAL?  yes  no DID THE INJURY CAUSE STUDENT TO BE ABSENT?  yes  no NUMBER OF DAYS \_\_\_\_\_

10. NATURE OF INJURY (please enter appropriate codes for the injury and the area affected, if more than one begin with the most severe):

Injury	<b>Injury Codes:</b> 1. Cut      5. Bite      9. Broken Bone 2. Abrasion   6. Nosebleed   10. Burn 3. Bruise    7. Pain      11. _____ 4. Sprain    8. Concussion (or suspected)	Area affected	<b>Area Affected Codes:</b> 1. Head   5. Eye   9. Shoulder   13. Elbow   17. Stomach   21. Ankle 2. Face   6. Mouth   10. Back   14. Wrist   18. Hips/Buttocks   22. Foot 3. Ear   7. Chin   11. Chest   15. Hand   19. Legs   23. Toe 4. Nose   8. Neck   12. Arm   16. Finger   20. Knee   24.
a. Most Severe _____		a. Most Severe _____	
b. Other (if any) _____		b. Other (if any) _____	
c. Other (if any) _____		c. Other (if any) _____	

11. DESCRIPTION OF INCIDENT (MUST BE COMPLETED) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

12. WAS A SCHOOL RULE VIOLATED?  yes  no By Whom? (explain) \_\_\_\_\_

13. OTHER CONTRIBUTING FACTORS (Check all that apply) . . . . .

<input type="checkbox"/> Animal bite	<input type="checkbox"/> Chemical Contact/inhalation/ingestion	<input type="checkbox"/> Foreign body/object in eye	<input type="checkbox"/> Fall
<input type="checkbox"/> Contact with heat/flame	<input type="checkbox"/> Contact with equipment (pe/lab/shop/etc.)	<input type="checkbox"/> Hit by thrown/flying object	<input type="checkbox"/> Human bite
<input type="checkbox"/> Fighting/roughhousing	<input type="checkbox"/> Collision with person/object	<input type="checkbox"/> Seizure disorder	<input type="checkbox"/> Unknown
<input type="checkbox"/> Insect bite/sting	<input type="checkbox"/> Tripped/slipped	<input type="checkbox"/> Compression/pinch	<input type="checkbox"/> _____

Questions 14, 15, 16, 17: CIRCLE THE CODE(S) WHICH APPLY, IN EACH CATEGORY.

<b>14 - ACTIVITY CODES:</b> 1. Competitive Sport 2. Physical Ed. a. Football b. Baseball/Softball c. Basketball d. Soccer e. Track/Field f. Swimming/Diving g. Wrestling h. Gymnastics i. Cheerleading j. _____ 3. Classroom Instruct. a. Arts/Crafts	b. Agriculture c. Homemaking d. Laboratory Science e. Metal/Welding Shop f. Performing Arts g. Wood Shop h. Classroom i. _____ 4. Recess (specify) a. Supervised Activity b. Unsupervised Activity 5. Field Trip 6. Transportation	7. Food Service 8. Athletic Event 9. _____ 10. _____ 11. _____ <b>15 - LOCATION CODES</b> 1. Gymnasium 2. Shower/dressing room 3. Playing field 4. Hard surface play court 5. Swing 6. Slide 7. Climber	8. Sand Box 9. Classroom 10. Kitchen/Dining room/cafeteria 11. Auditorium 12. Office 13. Hallway 14. Sidewalk 15. Driveway/Parking Area 16. _____ 17. _____ <b>16 - SURFACE CODES</b> 1. Carpet 2. Hard Flooring 3. Concrete 4. Asphalt 5. Grass 6. Bare Dirt 7. Sand 8. Gravel 9. Wood Chips 10. Soft Mat 11. _____ <b>17 - PERIOD CODES</b> 1. Before School 2. During School (if high school Please specify 1 <sup>st</sup> period, 2 <sup>nd</sup> Pe etc.) 3. During lunch or other break period. 4. During a school program 5. After School 6. _____ 7. _____
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18. ACTIONS TAKEN BY SCHOOL (Please complete all that apply):

<input type="checkbox"/> First aid administered	Time: _____ AM/PM	By whom _____	Job Title: _____
<input type="checkbox"/> Parent/guardian notified	Time: _____ AM/PM	By whom _____	Job Title: _____
<input type="checkbox"/> Unable to reach parent	Time: _____ AM/PM	<input type="checkbox"/> Returned to class	<input type="checkbox"/> Sent/taken home
<input type="checkbox"/> Checked by school nurse/EMT/Paramedic _____		<input type="checkbox"/> Taken to hospital/emergency facility _____	

19. ACTIONS TAKEN BY PARENT (if applicable, PLEASE indicate information below)

Parents deemed no medical action necessary \_\_\_\_\_

Taken to Doctor/Hospital/Emergency Facility \_\_\_\_\_ Diagnosis \_\_\_\_\_

Restricted school activities (what & how long) \_\_\_\_\_

SUBMITTED BY: \_\_\_\_\_ TITLE: \_\_\_\_\_

**DISTRICT OFFICE USE:**

Corrective action taken: \_\_\_\_\_