

Whitewater School District #20D Student Injury Report

Student information

Name			Date of incident		
Date of birth	Grade	<input type="checkbox"/> Male <input type="checkbox"/> Female	Time of incident		

Parent/guardian information

Name(s)			Work phone ()		
Address			Home phone ()		
City	State	ZIP	Cell phone ()		

School information

School	Phone ()
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Location of incident check appropriate box

- | | | | | | |
|---|------------------------------------|------------------------------------|--------------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Athletic field | <input type="checkbox"/> Cafeteria | <input type="checkbox"/> Gymnasium | <input type="checkbox"/> Parking lot | <input type="checkbox"/> Restroom | <input type="checkbox"/> Vocation shop/lab |
| <input type="checkbox"/> Bus | <input type="checkbox"/> Classroom | <input type="checkbox"/> Hallway | <input type="checkbox"/> Playground | <input type="checkbox"/> Stairway | |
- Other *explain*

Time of incident check appropriate box

- | | | | | | |
|--|---------------------------------------|-------------------------------------|--|---------------------------------------|-------------------------------------|
| <input type="checkbox"/> Recess | <input type="checkbox"/> Lunch | <input type="checkbox"/> P.E. class | <input type="checkbox"/> In class (not P.E.) | <input type="checkbox"/> Class change | <input type="checkbox"/> Field trip |
| <input type="checkbox"/> Before school | <input type="checkbox"/> After school | <input type="checkbox"/> Unknown | | | |
- Other *explain*

Athletic practice/session:

- Athletic team competition Intramural competition

Equipment

- No equipment involved Equipment involved *describe*

Surface check all that apply

- | | | | | | | |
|----------------------------------|-----------------------------------|--|-------------------------------------|---------------------------------|--|---|
| <input type="checkbox"/> Asphalt | <input type="checkbox"/> Concrete | <input type="checkbox"/> Gravel | <input type="checkbox"/> Ice/snow | <input type="checkbox"/> Mat(s) | <input type="checkbox"/> Synthetic surface | <input type="checkbox"/> Wood chips/mulch |
| <input type="checkbox"/> Carpet | <input type="checkbox"/> Dirt | <input type="checkbox"/> Gymnasium floor | <input type="checkbox"/> Lawn/grass | <input type="checkbox"/> Sand | <input type="checkbox"/> Tile | |
- Other *specify*

Type of injury check all that apply

	Head	Eye	Ear	Nose	Mouth/lips	Tooth/teeth	Jaw	Chin	Neck/throat	Collarbone	Shoulder	Upper arm	Elbow	Forearm	Wrist	Hand	Finger	Fingernail	Chest/ribs	Back	Abdomen	Groin	Genitals	Pelvis/hip	Leg	Knee	Ankle	Foot	Toe
Abrasion/scrape																													
Bite																													
Bump/swelling																													
Bruise																													
Burn/scald																													
Cut/laceration																													
Dislocation																													
Fracture																													
Pain/tenderness																													
Puncture																													
Sprain																													
Other																													

Contributing factors *check all that apply*

- | | | | | |
|--|--|---|---|--|
| <input type="checkbox"/> Animal bite | <input type="checkbox"/> Compression/pinch | <input type="checkbox"/> Fall | <input type="checkbox"/> Overextension/twisted | <input type="checkbox"/> Struck by object (bat, swing, etc.) |
| <input type="checkbox"/> Collision with object | <input type="checkbox"/> Contact with hot or toxic substance | <input type="checkbox"/> Foreign body/object | <input type="checkbox"/> Physical Altercation | <input type="checkbox"/> Tripped/slipped |
| <input type="checkbox"/> Collision with person | <input type="checkbox"/> Drug, alcohol or other substance involved | <input type="checkbox"/> Hit with thrown object | <input type="checkbox"/> Struck by auto, bike, etc. | |
| <input type="checkbox"/> Weapon <i>specify</i> | | <input type="checkbox"/> Other <i>explain</i> | | |

Description of the incident

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Witnesses to the incident

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Staff involved *check all that apply*

- | | | | | |
|--|--|------------------------------------|------------------------------------|---|
| <input type="checkbox"/> Assistant staff | <input type="checkbox"/> Cafeteria staff | <input type="checkbox"/> Nurse | <input type="checkbox"/> Secretary | <input type="checkbox"/> Other <i>specify</i> |
| <input type="checkbox"/> Bus driver | <input type="checkbox"/> Custodian | <input type="checkbox"/> Principal | <input type="checkbox"/> Teacher | |

Incident response *check all that apply*

<input type="checkbox"/> First Aid	Time	By whom	
<input type="checkbox"/> Called 911	Time	By whom	
<input type="checkbox"/> Parent/guardian notified	Time	By whom	
<input type="checkbox"/> Unable to contact parent/guardian	Time	By whom	
<input type="checkbox"/> Parents deemed no medical action necessary	<input type="checkbox"/> Returned to class	<input type="checkbox"/> Sent/taken home	Days of school missed
<input type="checkbox"/> Taken to health care provider / clinic/hospital/urgent care	Diagnosis		Days of school missed
<input type="checkbox"/> Hospitalized	Diagnosis		Days of school missed
<input type="checkbox"/> Restricted school activity	Explain	Length of time restricted	Days of school missed
<input type="checkbox"/> Other <i>explain</i>			

Describe care provided to the student

Additional comments

Signature of staff member completing form	Date/time
Nurse's signature	Date/time
Principal's signature	Date/time