



Accident or Injury Report

1.	SCHOOL:	
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2.	DATE: ___/___/___	TIME: ___:___ AM / PM	DAY OF WEEK:
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3.	NAME:	
CHECK ONE ONLY: <input type="checkbox"/> Student - Grade: _____ <input type="checkbox"/> Employee - Department: _____ <input type="checkbox"/> Visitor <input type="checkbox"/> Other: _____		

4.	LOCATION OF INCIDENT:	<input type="checkbox"/> Athletics <input type="checkbox"/> Cafeteria <input type="checkbox"/> Classroom <input type="checkbox"/> Gymnasium <input type="checkbox"/> Office <input type="checkbox"/> Hallway <input type="checkbox"/> In-Transit <input type="checkbox"/> Playground <input type="checkbox"/> Other: _____
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5.	DESCRIPTION OF ACCIDENT:

6.	IMMEDIATE TREATMENT OF INJURY:

7.	INJURED PERSON SENT TO:	<input type="checkbox"/> Classroom <input type="checkbox"/> Doctor's Office <input type="checkbox"/> Home <input type="checkbox"/> Hospital <input type="checkbox"/> School Nurse <input type="checkbox"/> Sick Room <input type="checkbox"/> Other: _____
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8.	NOTIFICATION MADE TO: (Check all that apply)	<input type="checkbox"/> Supervisor <input type="checkbox"/> Principal <input type="checkbox"/> Parent <input type="checkbox"/> Other: _____
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9.	ACTION OF PERSON NOTIFIED:	
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10.	WITNESSES:	
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11.	RESULTS OF INJURY OR ACCIDENT:	
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12.	TIME LOST OUT OF SCHOOL:	
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13.	INSURANCE FORM PROVIDED TO PARENT:	<input type="checkbox"/> No <input type="checkbox"/> Yes - Date Given: _____
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14.	Reported by:	_____ Signature	Date:	___/___/___
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☞ This form does not replace WCC Form N, Employee's Notice of Injury.
 ☞ Send this form to: STUDENT SERVICES SUPERVISOR - SERVICE CENTER