ISD#110 Waconia Public Schools Learning for Life

ACCIDENT FORM

TODAY'S DATE:

NAME:

☐ **STUDENT** ☐ **OTHER**

DATE OF ACCIDENT: **TIME OF ACCIDENT:** **LOCATION OF ACCIDENT:**

Type of Accident:

☐ Abrasion	☐ Head Injury
☐ Burn	☐ Fracture
☐ Bruise/Bump	☐ Laceration
☐ Cut	☐ Puncture
☐ Convulsion	☐ Shock
☐ Dislocation	☐ Sprain
	☐ Other

Part of Body injured:

☐ Abdomen	☐ Face
☐ Ankle	☐ Finger
☐ Arm	☐ Foot
☐ Back	☐ Hand/Wrist
☐ Chest	☐ Head
☐ Elbow	☐ Knee
☐ Eye	☐ Leg
☐ Mouth/Teeth	☐ Other

HOW DID ACCIDENT HAPPEN:

HEALTH ASSESSMENT:

TREATMENT ADMINISTERED:

Exposure Incident: an individual's blood or other potentially infectious body fluid contacting another persons mucous membrane, non-intact skin, or a puncture into the skin. Was an exposure involved? ☐ YES ☐ NO
If YES, please fill out an exposure form for all individuals.

FOLLOW UP:

PARENT NAME/ADDRESS:

Parent Phone #: **Communication:**

Clinic/Doctor: **Phone #:**

PERSON COMPLETING FORM: **Date:**

WITNESS SIGNATURE: **Date:**

ADMINISTRATOR SIGNATURE: **Date:**

The District Office will contact the Insurance Carrier and they will contact the injured party.

☐ **FORM SENT TO M I S T**

07/15 **DATE SENT:**