

BILLINGS PUBLIC SCHOOLS

ACCIDENT REPORT FORM

This report should be completed for injuries which require immediate or future intervention. The original copy is to be sent to the Business Office Secretary at the Lincoln Center; the copy retained in the School.

Name of Injured: _____ Birthdate: _____

Address: _____ Phone: _____ Sex: _____

School: _____ Grade: _____ Student:

Date of Injury: _____ Time of Day: _____ Activity Involved: _____

Describe accident: (Specific location, condition of premises, equipment involved, what happened)

First Aid action taken:

By whom: _____ Parent notified: Yes No By: _____

Medical care recommended: Yes No Explain: _____

Where taken after accident: (Specify home, physician, hospital, home and address): _____

How transported: _____ By whom: _____

Witnesses familiar with circumstances:

Name _____ Address _____ Phone _____

Name _____ Address _____ Phone _____

REPORT OF CONDITION AT TIME OF ACCIDENT

Check appropriate observation: Normal Alert Overactive - Listless Unable to arouse

Skin condition: Within Normal Limits Pale Dry Moist Cool Warm

Indicate on diagram location of injury. Describe appearance of injury. _____

Any pertinent health history, characteristics, or limitations: _____

Follow up information: _____

Report completed by: _____ Date: _____

Caregiver's Signature: _____

Title: _____ Date: _____

Principal's Signature: _____ Date: _____

