

# PUBLIC ACCIDENT/INCIDENT REPORT FORM

## School Alliance Insurance Fund

THIS REPORT IS TO BE FILLED OUT BY A RESPONSIBLE INDIVIDUAL IN THE DISTRICT WHO HAS THE ACCIDENT & INJURY REPORTED TO THEM.

School District:	Location of accident (Please be specific):	Date of accident:	Time of Accident: ____:____ AM ____:____ PM
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Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_

Was injured party an invited guest in the district? \_\_\_\_ YES (Event/Visit) \_\_\_\_ NO  
IF TREATED BY SCHOOL DISTRICT PERSONNEL,

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Treatment was (check one): \_\_\_\_ First Aid \_\_\_\_ Medical \_\_\_\_ Hospitalization

Home phone : \_\_\_\_\_

Treatment Provided by: \_\_\_\_\_

Business Phone : \_\_\_\_\_

Type of Treatment: (If provided by District Personnel)

**WITNESS:**

Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home phone: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Bus: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

INJURED PARTY'S DESCRIPTION OF ACCIDENT:

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Copy of this report sent to Risk Management Consultant? \_\_\_\_ Yes \_\_\_\_ No

\_\_\_\_\_  
Signature of Party Filling Out This Form.

**STOP!**

THE REMAINDER OF THIS FORM IS FOR ACCIDENTS THAT REQUIRE MEDICAL ATTENTION, HOSPITALIZATION, OR A FATAL INJURY ONLY.

ACCIDENT/INCIDENT DETAILS (When answering the questions that follow, bear in mind that it is important to get to the root cause of the accident. So investigate the situation thoroughly. Don't settle for the obvious answer.)

DESCRIBE WHAT INJURED PARTY WAS DOING JUST PRIOR TO AND AT THE TIME OF THE ACCIDENT -

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WERE WRITTEN OR ACCEPTED RULES OF THE SCHOOL FOLLOWED PRIOR TO THE ACCIDENT/INCIDENT? IF NOT, EXPLAIN:

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WHAT CAUSED THE ACCIDENT?

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**ACCIDENT CLASSIFICATIONS (CHECK ONE IN EACH CATEGORY)**

**TYPE OF ACCIDENT:**

Caught In/Between	Slip/Trip	Lifting, Carrying, Reaching	Collision/Upset of Vehicle	Inhalation	Cumulative Trauma
Struck By	Fall - Same Level	Pushing or Pulling	Foreign Body	Ingestion	Walk, Run, Jumping
Struck Against	Fall - Different Level	Twisting, Bending, Stretching	Cut/Puncture/Scrape	Exposure To:	Contact With
Sports Activity	OTHER (Explain):				

**AGENCY OF ACCIDENT**

Machinery	Hand Tool	Ladder	Scaffold	Work Platform	Pressure Vessel
Floor	Stairs	Elevator	Ramp	Walkway	Foreign Body
Parking Lot	Chemical	Water	Snow/Ice	Electrical	Sports Equip.
Chemical	Vehicle	Power Equip.	Grease/Oil	Ground (Grass/Other)	Elec.. Cords
Human	Bleachers/Bench	OTHER (Explain):			

**BODY PART AFFECTED**

Head & Neck		Upper Extremities		Body		Lower Extremities	
Head		Shoulder	R - L	Back		Hip	R - L
Scalp/Skull		Upper Arm	R - L	Chest		Thigh	R - L
Eye	R - L	Elbow	R - L	Abdomen		Knee	R - L
Ear	R - L	Forearm	R - L	Groin		Lower Leg	R - L
Nose		Wrist	R - L	Body-Multiple		Ankle	R - L
Face		Hand	R - L			Foot	R - L
Mouth		Fingers				Toe(s)	
Neck		Multiple				Multiple	

**TYPE OF INJURY**

Laceration	Puncture	Concussion	Contusion	Irritation	Insect Bite
Hernia	Dislocation	Strain/Sprain	Poisoning	Amputation	Other _____
Shock (Elec.)	Fracture	Abrasion	Hearing Loss	Exposure	
Burn	Burn (Chemical)	Dermatitis	Heat Exhaustion	Asphyxia	

**CORRECTIVE ACTION**

**WHAT COULD HAVE PREVENTED THE ACCIDENT/INCIDENT?**

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**WHAT ACTIONS HAVE BEEN, OR SHOULD BE, TAKEN TO REDUCE THE LIKELIHOOD OF ACCIDENTS OF THIS NATURE FROM RECURRING?**

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**NOTE: ADDITIONAL COMMENTS AND/OR NOTES CAN BE ADDED TO A SEPARATE PIECE OF PAPER IF NEEDED.**

Supervisor's Signature \_\_\_\_\_

Reviewed by: (For the District Safety Committee) \_\_\_\_\_

HAS CORRECTIVE ACTION BEEN TAKEN? YES \_\_\_ NO \_\_\_ If yes, date \_\_\_ / \_\_\_ / \_\_\_