

NEWTON PUBLIC SCHOOLS, USD 373

ATHLETIC INJURY/STUDENT ACCIDENT REPORT FORM

(Please complete all blanks and boxes, front and back of form. Send form to District Office ASAP following the injury/accident)

This form is to be completed immediately following the occurrence of any athletic/student injury that is severe enough to (a) cause the loss of one-half day or more of school, or (b) warrant medical attention (i.e. M.D., E.R., etc.).

A. NAME OF STUDENT: _____		B. SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female	C. AGE: _____
D. STUDENTS GRADE: <input type="checkbox"/> Kindergarten <input type="checkbox"/> 1 st Grade <input type="checkbox"/> 2 nd Grade <input type="checkbox"/> 3 rd Grade <input type="checkbox"/> 4 th Grade <input type="checkbox"/> 5 th Grade <input type="checkbox"/> 6 th Grade <input type="checkbox"/> 7 th Grade <input type="checkbox"/> 8 th Grade <input type="checkbox"/> 9 th Grade <input type="checkbox"/> 10 th Grade <input type="checkbox"/> 11 th Grade <input type="checkbox"/> 12 th Grade <input type="checkbox"/> Other (specify) _____			
E. STUDENT IDENTIFICATION NUMBER: <u>75302</u>		F. SCHOOL: _____	
G. NATURE OF INJURY: <input type="checkbox"/> Abrasion/Scrape <input type="checkbox"/> Asphyxiation <input type="checkbox"/> Bite/Sting <input type="checkbox"/> Bruise/Contusion <input type="checkbox"/> Burn/Scald <input type="checkbox"/> Concussion (possible) <input type="checkbox"/> Cut/Laceration <input type="checkbox"/> Dental <input type="checkbox"/> Dislocation (possible) <input type="checkbox"/> Fracture (possible) <input type="checkbox"/> Internal injury (possible) <input type="checkbox"/> Ligaments/Cartilage <input type="checkbox"/> Loss of consciousness <input type="checkbox"/> Poisoning <input type="checkbox"/> Shock (electrical) <input type="checkbox"/> Sprain/Strain <input type="checkbox"/> Other (specify) <u>Knee injury</u>			
H. PART OF BODY INJURED: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Shoulder <input type="checkbox"/> Arm <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Hand <input type="checkbox"/> Fingers <input type="checkbox"/> Pelvis/Hip <input type="checkbox"/> Leg <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Foot <input type="checkbox"/> Toes <input type="checkbox"/> Head <input type="checkbox"/> Ear <input type="checkbox"/> Face <input type="checkbox"/> Eye <input type="checkbox"/> Nose <input type="checkbox"/> Mouth <input type="checkbox"/> Teeth <input type="checkbox"/> Neck <input type="checkbox"/> Collarbone <input type="checkbox"/> Back <input type="checkbox"/> Chest <input type="checkbox"/> Ribs <input type="checkbox"/> Abdomen <input type="checkbox"/> Buttocks <input type="checkbox"/> Genitalia <input type="checkbox"/> Internal <input type="checkbox"/> Other (specify) _____			

I. ACTION TAKEN: (If any action was taken after the incident, please CHECK AND COMPLETE ALL THAT APPLY.)

By School

- First aid administered
- Parent or guardian notified
- Unable to contact parent/guardian
- Remained in or returned to class
- Sent/taken home
- Checked by Certified Athletic Trainer
- Checked by School Nurse
- Checked by Paramedics/EMT's
- Referred to physician
- Referred to emergency care facility or hospital
- Other (specify): _____

By Parent/Guardian

- Parent/Guardian deemed no medical action necessary
- Taken to physician
- Taken to emergency care facility or hospital
- Hospitalized, Specify length: _____
- Restricted school activity, Specify length: _____

J. DAYS ABSENT: Amount of time/days student was absent from school related to this injury/accident: _____

NAME OF STUDENT: _____

K. DATE OF ACCIDENT: ____ / ____ / ____ (MM/DD/YYYY)

L. TIME OF ACCIDENT: ____ : ____ AM PM

M. PLACE OF ACCIDENT: School Building School Grounds Elsewhere – Specify: _____

- N. LOCATION OF ACCIDENT:**
- | | | |
|---|--|---|
| <input type="checkbox"/> Athletic field | <input type="checkbox"/> Auditorium/Gym | <input type="checkbox"/> Bus |
| <input type="checkbox"/> Cafeteria | <input type="checkbox"/> Classroom | <input type="checkbox"/> Corridor |
| <input type="checkbox"/> Dressing/Locker Room | <input type="checkbox"/> Golf Course | <input type="checkbox"/> Industrial Education shop |
| <input type="checkbox"/> Lake/River/Body of water | <input type="checkbox"/> Parking area | <input type="checkbox"/> Public building, All other |
| <input type="checkbox"/> Restroom | <input type="checkbox"/> Showers | <input type="checkbox"/> Sidewalk |
| <input type="checkbox"/> Stairs (Indoor) | <input type="checkbox"/> Street/Highway | <input type="checkbox"/> Stairs (Outdoor) |
| <input type="checkbox"/> Stairs (Outdoor) | <input type="checkbox"/> Swimming Pool | <input type="checkbox"/> Tennis Courts |
| <input type="checkbox"/> Track | <input type="checkbox"/> Weight/Wrestling Room | <input type="checkbox"/> Yard/Field |
| <input type="checkbox"/> Other (Specify) _____ | | |

- O. PERIOD CODE:**
- | | | |
|--|---|--|
| <input type="checkbox"/> Interschool Competition | <input type="checkbox"/> Intramural Competition | <input type="checkbox"/> P.E. Class |
| <input type="checkbox"/> Sports Practice | <input type="checkbox"/> Off Season Training | <input type="checkbox"/> Other (specify) _____ |

- P. ACTIVITY CODE:**
- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Baseball | <input type="checkbox"/> Basketball | <input type="checkbox"/> Cheerleading |
| <input type="checkbox"/> Concert (Band/Music) | <input type="checkbox"/> Cross Country | <input type="checkbox"/> Dance Team |
| <input type="checkbox"/> Drama (Play/Musical) | <input type="checkbox"/> Football (Tackle) | <input type="checkbox"/> Forensics |
| <input type="checkbox"/> Golf | <input type="checkbox"/> Football (Touch) | <input type="checkbox"/> Recess |
| <input type="checkbox"/> Softball | <input type="checkbox"/> Gymnastics/Tumbling | <input type="checkbox"/> Hockey |
| <input type="checkbox"/> Volleyball | <input type="checkbox"/> Soccer | <input type="checkbox"/> Tennis |
| <input type="checkbox"/> Track/Field Event | <input type="checkbox"/> Weight Training | <input type="checkbox"/> Wrestling |
| <input type="checkbox"/> Other (specify) _____ | | |

Q. DESCRIPTION: Describe specifically how the accident/injury occurred:

R. SUPERVISION/WITNESS: Under whose supervision was the student? _____

Was he/She a witness? Yes No

Name: _____ Address: _____

Name: _____ Address: _____

Signature of Person Making Report	Title	Date / /
Date Received in Central Office: / / Received By: _____		