POLAND CENTRAL SCHOOL ACCIDENT REPORT

74 Cold Brook Street, POLAND, NY 13431 ~ phone: (315) 826-7000 ~ fax: (315) 826-5509

PLEASE NOTE: This report must be submitted to the Nurse WITHIN 24 HOURS of school day accident or within 48 hours for Saturday occurrences.

Student Name: _____ Grade: _____ Today's Date: _____

Date of Injury: _____ Time of Injury: _____ ☐ AM ☐ PM

ACCIDENT LOCATION (please check) Classroom_____ Gym_____ Playground _____ Bus_____ Other_____

OTHER DETAILS (check any that apply) Off school grounds _____ During athletic practice_____ During athletic game_____

CAUSE OF ACCIDENT (please check)

Collision with person_____ Collision with obstacle_____ Hit with projectile_____ Sudden turn, twist, stop_____

Fall_____ Fighting_____ Other (specify)_____

CONTRIBUTING CAUSES _____

WITNESSES _____

COMPLAINTS:

LEFT		RIGHT
	THUMB	
	FINGERS	
	HAND	
	WRIST	
	LOWER ARM	
	UPPER ARM	
	ELBOW	
	SHOULDER	

LEFT		RIGHT
	TOES	
	FOOT	
	ANKLE	
	KNEE	
	LOWER LEG	
	UPPER LEG	
	HIP	

LEFT		RIGHT
	TRUNK	
	BACK	
	ABDOMEN	
	HEAD	
	NECK	
	FACE	
	EYE	
OTHER:		

RX ADMINISTERED ON SITE

Iced_____ Washed wound_____ Bandaged_____ Applied dressing_____ Applied sling_____ Observation only_____

A. NAME OF PERSON COMPLETING REPORT

B. MEANS OF PARENT/GUARDIAN NOTIFICATION: Phone_____ Voicemail_____ Parent/Guardian Present_____

Time:_____ NOTIFYING PERSON (if not name written on line A):_____

OUTCOME ON INCIDENT DATE:

Return to class/activity_____ Student went home with parent/emergency contact_____ Parent sought MD ____ or ER____

DATE FORM RECEIVED BY MRS. DIVINE, RN:

ADDITIONAL NOTES FROM MRS. DIVINE, RN: