ACCIDENT REPORT

This form is to be completed by the appropriate employee(s) as soon as possible after an accident occurs

PLEASE PRINT OR TYPE

District Name Marion County Schools School Name Select School

Principal's Name _____ School Phone _____ Date Reported _____

Date of Accident _____ Time _____ ☐ AM ☐ PM Supervising Employee _____

Claimant's Name _____
Last Name First Name Middle Initial

Claimant's Address _____
Street City State ZIP Code

Claimant's SSN _____ Home Phone Number _____

Claimant's Age _____ Date of Birth _____ Sex _____ Grade _____

Parent's Name (if student) _____ Work Phone Number _____

Nature of Injury		Place of Accident		Body Part Injured		
☐ Scratch	☐ Concussion	☐ Classroom	☐ Gymnasium	☐ Ankle	☐ Foot	☐ Leg
☐ Fracture	☐ Head Injury	☐ Hallway	☐ Parking Lot	☐ Arm	☐ Face	☐ Nose
☐ Bruise	☐ Sprain/Strain	☐ Bathroom	☐ Sidewalk	☐ Back	☐ Finger	☐ Teeth
☐ Burn	☐ Cut/Puncture	☐ Cafeteria	☐ Stairs	☐ Neck	☐ Hand	☐ Wrist
☐ Dislocation	☐ Bite	☐ Playground	☐ Athletic Field	☐ Eye	☐ Knee	☐ Shoulder
☐ Other _____		☐ Other _____		☐ Other _____		

Describe the accident and injury in detail

Were efforts made to contact the parent/guardian about the accident? ☐ Yes ☐ No

Was First aid administered? ☐ Yes ☐ No By whom? _____

Was the student ☐ Sent home ☐ Sent to physician ☐ Sent to hospital

Is the student covered by Student Accident Insurance? ☐ Yes ☐ No If yes, please list Company Name, address

And phone number _____

IF MEDICAL OR HOSPITAL TREATMENT WAS REQUIRED, PLEASE COMPLETE THE FOLLOWING:
(Attach a copy of medical bills, if available)

Name and address of doctor or hospital _____

Witnesses (Name Address & Phone _____

_____ _____
Signature of Person Completing the Report Date