



Indiana Insurance™
Member of Liberty Mutual Group

Standard School Incident Report

Name of School	School District	
Name of Injured Party	Date of Accident	Time of Accident <input type="checkbox"/> am <input type="checkbox"/> pm
Address	Age	Sex
	Grade or Position	
	Status <input type="checkbox"/> Employee <input type="checkbox"/> Student <input type="checkbox"/> Visitor <input type="checkbox"/> Trespasser <input type="checkbox"/> Other, describe:	

Description of Accident (How did the accident happen? What was the injured person doing? What tool, machine or equipment was involved? What teacher, supervisor or administrator was responsible for the area? Who witnessed the accident?)

Witness Name - 1	Address	Telephone Number
Witness Name - 2	Address	Telephone Number
Witness Name - 3	Address	Telephone Number

Location	Type of Injury	Body Part(s) Affected		
<input type="checkbox"/> Athletic Field <input type="checkbox"/> Bus <input type="checkbox"/> Bus Stop <input type="checkbox"/> Cafeteria <input type="checkbox"/> Classroom <input type="checkbox"/> Gymnasium <input type="checkbox"/> Hallway <input type="checkbox"/> Laboratory <input type="checkbox"/> Locker Room <input type="checkbox"/> Maintenance Area <input type="checkbox"/> Other _____	<input type="checkbox"/> Office <input type="checkbox"/> Playground <input type="checkbox"/> Restroom <input type="checkbox"/> Sidewalk <input type="checkbox"/> Swimming Pool Area <input type="checkbox"/> Stairs (Inside) <input type="checkbox"/> Stairs (Outside) <input type="checkbox"/> Theater or Stage <input type="checkbox"/> Vocational Shops <input type="checkbox"/> Off-Premises <input type="checkbox"/> Other (describe) _____	<input type="checkbox"/> Abrasion <input type="checkbox"/> Amputation <input type="checkbox"/> Asphyxiation <input type="checkbox"/> Bite (Animal or Insect) <input type="checkbox"/> Bite (Human) <input type="checkbox"/> Burn (Chemical) <input type="checkbox"/> Burn (Heat) <input type="checkbox"/> Concussion <input type="checkbox"/> Dislocation <input type="checkbox"/> Electrical Shock <input type="checkbox"/> Laceration <input type="checkbox"/> Fracture <input type="checkbox"/> Poisoning <input type="checkbox"/> Puncture <input type="checkbox"/> Repetitive Motion <input type="checkbox"/> Sprain/Strain <input type="checkbox"/> Other (describe) _____	<input type="checkbox"/> Abdomen <input type="checkbox"/> Ankle <input type="checkbox"/> Arm <input type="checkbox"/> Back <input type="checkbox"/> Chest <input type="checkbox"/> Ear <input type="checkbox"/> Eye <input type="checkbox"/> Face <input type="checkbox"/> Other (describe) _____	<input type="checkbox"/> Finger <input type="checkbox"/> Foot <input type="checkbox"/> Hand <input type="checkbox"/> Head <input type="checkbox"/> Leg <input type="checkbox"/> Mouth <input type="checkbox"/> Tooth <input type="checkbox"/> Wrist

Immediate Action Taken

None

First Aid provided. Given by: _____

Medical Ambulance called. Time of Call: _____ By: _____

School Nurse notified. Time of Call: _____ By: _____

Parent/Guardian notified. Time of Call: _____ By: _____

Name of Parent/Guardian notified: _____

Parents/Guardian Telephone Number: _____ (Home) _____ (Work)

Injured person released to Self Home Class Physician Hospital Other _____

Time released: _____

Report Completed By: _____ Title: _____

Date: _____ Telephone Number: _____

NOTE: This report is for record purposes only and does not constitute the admission of liability on the part of the school system or any employee thereof.

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