

# Wayland Union Schools

## Student / Visitor Accident Report

(To be completed immediately after incident/accident occurs)  
Please complete all blanks. If not applicable, so indicate by N/A

<b>Building:</b>	<b>Date:</b>	<b>Time:</b>	<b>AM or PM</b>
<b>Classification:</b> Student <input type="checkbox"/> Visitor <input type="checkbox"/> Other <input type="checkbox"/>			
<b>Name of injured person:</b>	<b>Social Security #</b>		
<b>Address:</b>	<b>Telephone #</b>		
<b>Birthday :</b> Mo _____ Day _____ Year _____			
<b>Gender:</b> Male <input type="checkbox"/> Female <input type="checkbox"/>		<b>Marital Status:</b> Married <input type="checkbox"/> Single <input type="checkbox"/>	
<b>Date of injury:</b>	<b>Was injury fatal?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>		
<b>Location of accident: Building:</b>		School grounds _____ School bus _____	
<b>Place of accident:</b> Classroom _____ Gym _____ Hallway/Stairway _____ Playground _____ Entryway _____			
<b>County:</b> Shop _____ Parking Lot _____ Sporting Event/Practice _____ Other _____			
<b>Describe how the injury occurred:</b>			
<b>Describe initial treatment:</b>			
<b>Name and address of attending doctor:</b>			
<b>If hospitalized, name and address of hospital:</b>			
<b>Describe the type of injury or illness (example – burn, cut, fracture):</b>			
<b>Part of body directly affected (example – left hand, right arm, left eye):</b>			
<b>Describe the events that caused the injury (example – fell, tripped):</b>			
<b>Name the object or substance which directly caused the injury:</b>			
<b>Witnesses to accident    1. Name and contact number:</b>			
<b>2. Name and contact number:</b>			

**STUDENT:**

School:	Grade:
Was an instructor present? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, instructor's name:	
If no, was another employee present? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, name:	
Was family notified? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, time:	By whom:
Name of parent or guardian:	

**VISITOR / OTHER:**

Additional contact information:
Additional comments:

Signature of injured person: \_\_\_\_\_

Signature of witness: \_\_\_\_\_

Signature of supervisor on duty at time of injury: \_\_\_\_\_

Today's date: \_\_\_\_\_

**Wayland Union Schools  
850 E Superior St  
Wayland, MI 49348  
269.792.2181**

**Send Form to HUMAN RESOURCES within 48 Hours of Incident / Accident  
[atwoodc@waylandunion.org](mailto:atwoodc@waylandunion.org) OR 269.792.1615 fax**