

Ogle County Educational Cooperative

417 N. Colfax St. – P.O. Box 582

Byron, IL 61010

Phone (815) 234-2722 – Fax (815) 234-2938

STANDARD ACCIDENT REPORT

Instructions:

- 1) After completing this form, forward the original to: Jennifer Riley, and copies to: 1) Mike Noble 2) Tammy Moser.
- 2) This report should be completed for any injury that requires a doctor's attention or has the potential to become a serious injury.
- 3) This report is to be completed by the person sustaining the injury (if an adult) or by a staff member or adult witness if the injury is sustained by a minor.
- 4) This report is to be filled out within 24 hours after the occurrence.

Name of injured: _____	
Attendance Center: _____	(Parent Name): _____
Date of Report: _____	Phone Number: _____
Prepared by: _____	Street Address: _____
Title/Position: _____	P.O. Box: _____
Date of accident: _____	City, State, Zip: _____
Time of accident: _____	Age: _____ (Grade): _____ Sex: _____
Where did accident occur? _____	How did the accident occur: (Describe the event and injury in detail)
Street Address: _____	
City, State: _____	
Is this site under school jurisdiction? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Activity at time of the accident:	Was police report filed? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Normal classroom activity	Was accident fatal? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Lab or shop work	Was accident due to unsafe act or condition? (explain)
<input type="checkbox"/> Going to or from school	
<input type="checkbox"/> Physical education	
<input type="checkbox"/> Other _____	
Nature of injury:	Location of injury on body: (check most serious)
<input type="checkbox"/> Amputation	<input type="checkbox"/> Eyes
<input type="checkbox"/> Burn or scald (heat or chemical)	<input type="checkbox"/> Head, face, neck (except teeth)
<input type="checkbox"/> Dislocation	<input type="checkbox"/> Teeth
<input type="checkbox"/> Cut, laceration, puncture, abrasion	<input type="checkbox"/> Back
<input type="checkbox"/> Concussion	<input type="checkbox"/> Arm
<input type="checkbox"/> Crushing injury	<input type="checkbox"/> Hand, wrist
<input type="checkbox"/> Fracture	<input type="checkbox"/> Leg, knee
<input type="checkbox"/> Bruise, contusion	<input type="checkbox"/> Feet, ankles, toes
<input type="checkbox"/> Poison	<input type="checkbox"/> Other _____
<input type="checkbox"/> Bite	
<input type="checkbox"/> Sprain, strain	
<input type="checkbox"/> Other, unknown _____	
Type of first aid given:	
By whom ?	
What was the result of the first aid?	
Who was notified about the accident?	When?
Is a Workman's Comp. claim involved? <input type="checkbox"/> Yes <input type="checkbox"/> No	

This report is: First Report

Revised Report

Signature: _____ Date: _____