Mission Consolidated Independent School District
Accident/Incident Report

☐ **Student** ☐ **Visitor** ☐ **Volunteer**

Name: _____ I.D. _____ Grade: _____ School: _____

☐ **Male** ☐ **Female** Age: _____ Date/Time of Accident: _____ Date reported: _____

Place of Accident: _____ Activity: _____

Nature of Injury: _____

_____

_____

Teacher in charge: _____ Present at scene? ☐ **Yes** ☐ **No** Witness: _____

First Aid Rendered/Evaluation: _____

_____

_____

By: _____

Referred to Nurse by: _____ Referred to: ☐ Physician ☐ Hospital ☐ Police ☐ Other

Parent/other person notified?: ☐ **Yes** ☐ **No** Name of Person Notified: _____

Relationship to child: _____ Time notified: _____ By whom: _____

Days lost from school: _____ Follow-up doctor's report: _____

**** Call-in serious incidents to Health Services. Send report when complete. ****

_____ _____

Principal's Signature Nurse's Signature

If necessary, attach an additional page to fully describe accident/incident

COPY TO DIRECTOR FOR RISK MANAGEMENT <u>IF NOT STUDENT</u>

6/2003