

<h1 style="margin: 0;">Wenatchee School District</h1>	<h2 style="margin: 0;">STUDENT ACCIDENT REPORT FORM</h2> <p style="margin: 0;">TO BE USED FOR ALL STUDENT ACCIDENTS</p>	<div style="border-bottom: 1px solid black; margin-bottom: 5px;">Person Completing Form</div> <div style="border-bottom: 1px solid black; margin-bottom: 5px;">Date</div>
PLEASE PRINT LEGIBLY FORM NEEDS TO BE COMPLETE!	Person in charge when accident occurred: _____ Present at time of accident? Yes <input type="checkbox"/> No <input type="checkbox"/>	

Use the STUDENT ACCIDENT REPORT FORM to record in your files each serious student accident coming under the jurisdiction of the school's authority. This form, when completed, should be filed in the school district office for future reference in case litigation may result from the accident at some future date. Minor accidents such as scratches, bruises, etc. need not necessarily be recorded.

Student's Name:	Home Address:	Phone Number:
School:	Gender: M <input type="checkbox"/> F <input type="checkbox"/>	Age:
Date of Accident:	Time of Accident:	Birthdate:

Nature of Injury (check all that apply)	Body Part Injured (check all that apply)	Location	Specify Activity (i.e. football, soccer during PE)
Abrasion <input type="checkbox"/>	<input type="checkbox"/>	Auditorium <input type="checkbox"/>	If the accident was the result of machine or equipment failure, specify the failure, in detail.
Accidental Contact <input type="checkbox"/>	Abdomen <input type="checkbox"/>	Bathroom <input type="checkbox"/>	
Animal Bite/Sting <input type="checkbox"/>	Ankle <input type="checkbox"/>	Bus/Bus Stop <input type="checkbox"/>	
Assault <input type="checkbox"/>	Arm <input type="checkbox"/>	Cafeteria <input type="checkbox"/>	
Assault w/Weapon <input type="checkbox"/>	Back <input type="checkbox"/>	Classroom <input type="checkbox"/>	
Athletic Injury (After school) <input type="checkbox"/>	Ear <input type="checkbox"/>	Gym <input type="checkbox"/>	
Athletic Injury (During school) <input type="checkbox"/>	Elbow <input type="checkbox"/>	Hallway <input type="checkbox"/>	
Bio-Hazard Exposure <input type="checkbox"/>	Eye <input type="checkbox"/>	Library <input type="checkbox"/>	
Bruise <input type="checkbox"/>	Face <input type="checkbox"/>	Locker Room <input type="checkbox"/>	
Burn/Scald <input type="checkbox"/>	Finger <input type="checkbox"/>	Off Campus <input type="checkbox"/>	
Chemical Exposure <input type="checkbox"/>	Foot <input type="checkbox"/>	Parking Lot <input type="checkbox"/>	
Chipped Tooth <input type="checkbox"/>	Hand <input type="checkbox"/>	Playground <input type="checkbox"/>	
Choking <input type="checkbox"/>	Head <input type="checkbox"/>	Restroom <input type="checkbox"/>	
Concussion Suspected <input type="checkbox"/>	Hip <input type="checkbox"/>	School Grounds <input type="checkbox"/>	
Electrical Injury <input type="checkbox"/>	Knee <input type="checkbox"/>	Shop <input type="checkbox"/>	
Eye Injury <input type="checkbox"/>	Leg <input type="checkbox"/>	Field <input type="checkbox"/>	
Fall From Elevated Surface <input type="checkbox"/>	Mouth <input type="checkbox"/>	Steps/Stairway <input type="checkbox"/>	
Fracture Suspected <input type="checkbox"/>	Nose <input type="checkbox"/>	Other <input type="checkbox"/>	
Hit By Foreign Object <input type="checkbox"/>	Shoulder <input type="checkbox"/>	(please describe)	
Horseplay <input type="checkbox"/>	Toe <input type="checkbox"/>		
Human Bite <input type="checkbox"/>	Wrist <input type="checkbox"/>		
Illness <input type="checkbox"/>	Other <input type="checkbox"/>		
Laceration <input type="checkbox"/>			
Medical Condition <input type="checkbox"/>			
Puncture Wound <input type="checkbox"/>			
Smashed <input type="checkbox"/>			
Struck Stationary Object <input type="checkbox"/>			
Trip/Slip <input type="checkbox"/>			
Vocational <input type="checkbox"/>			

In completing this accident report it is essential that the accident be described in sufficient detail to show conditions existing when the accident occurred. If unsafe acts or conditions are noted, steps should be taken immediately for their correction.

Description of Accident: (Use backside of sheet, if necessary)

Action Taken First Aid Treatment <input type="checkbox"/> Sent to School Nurse <input type="checkbox"/> Ambulance Called <input type="checkbox"/> Sent to Hospital <input type="checkbox"/> No treatment <input type="checkbox"/> Called Parents/Guardian (REQUIRED) <input type="checkbox"/> Sent Home <input type="checkbox"/> Other <input type="checkbox"/>	Action Taken By Whom: _____ Specify Action Taken: _____
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Witnesses: List all witnesses, use backside of sheet if necessary (if written statement is taken, please attach it to this form)		
Name:	Address:	Phone Number:
Name:	Address:	Phone Number:
Name:	Address:	Phone Number:
Name:	Address:	Phone Number:

All completed accident report forms should be filed in the nurse's office and the original form sent to the Josette Tran at the district office. (jt 2/21/25)

_____ Date: _____ Principal's Signature	_____ Date: _____ Staff/Coach's Signature
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