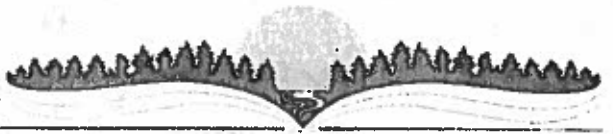


Canajoharie



Accident Report

SYMPTOMS OBSERVED

<input type="checkbox"/> Abrasion (scratch/scrape)	<input type="checkbox"/> Bee sting	<input type="checkbox"/> Foreign object	<input type="checkbox"/> Rash/blister
<input type="checkbox"/> Cut	<input type="checkbox"/> Bruise	<input type="checkbox"/> Insect bite	<input type="checkbox"/> Swelling
<input type="checkbox"/> Puncture (skin pierced by object)	<input type="checkbox"/> Bump	<input type="checkbox"/> Musculoskeletal	
	<input type="checkbox"/> Dental Injury	<input type="checkbox"/> Other	

Name:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	DOB: / /	Time:
School:	Age:	Grade:	Date:

LOCATION OF ACCIDENT

SCHOOL	<input type="checkbox"/> Auditorium	<input type="checkbox"/> Grounds	<input type="checkbox"/> Locker room	<input type="checkbox"/> Rest room
	<input type="checkbox"/> Cafeteria	<input type="checkbox"/> Gymnasium	<input type="checkbox"/> Playground	<input type="checkbox"/> Stairs
	<input type="checkbox"/> Classroom	<input type="checkbox"/> Hallway	<input type="checkbox"/> Pool	<input type="checkbox"/> Other:

PART OF BODY INJURED (Indicate left or right under Other)

<input type="checkbox"/> Abdomen	<input type="checkbox"/> Back	<input type="checkbox"/> Elbow	<input type="checkbox"/> Finger	<input type="checkbox"/> Head	<input type="checkbox"/> Mouth	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Wrist
<input type="checkbox"/> Ankle	<input type="checkbox"/> Chest	<input type="checkbox"/> Eye	<input type="checkbox"/> Foot	<input type="checkbox"/> Knee	<input type="checkbox"/> Nose	<input type="checkbox"/> Tooth	
<input type="checkbox"/> Arm	<input type="checkbox"/> Ear	<input type="checkbox"/> Face	<input type="checkbox"/> Hand	<input type="checkbox"/> Leg	<input type="checkbox"/> Scalp	<input type="checkbox"/> Other	

DESCRIPTION OF ACCIDENT: describe how the accident occurred and the activity the person was doing

FIRST AID & FOLLOW-UP CARE PROVIDED

<input type="checkbox"/> Area rinsed/washed	<input type="checkbox"/> Bandage applied	<input type="checkbox"/> Ice applied	<input type="checkbox"/> Rested/observed
<input type="checkbox"/> Medication administered:	Type:	Time given:	
<input type="checkbox"/> Other care provided:			

COMMUNICATION/NOTIFICATION WITH PARENTS/GUARDIANS

Parent/Guardian Notified:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date:	Time:
Notified via:	<input type="checkbox"/> Phone	<input type="checkbox"/> Message left	<input type="checkbox"/> Email <input type="checkbox"/> In-Person <input type="checkbox"/> Other

Person filling out this form signature: _____

Principal/ RN: _____