

CONFIDENTIAL SCHOOL INCIDENT INVESTIGATION

FOR INTERNAL USE ONLY:

DO NOT COPY OR DISTRIBUTE

SEND COMPLETED REPORT TO DISTRICT OFFICE

**ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE STRICTLY CONFIDENTIAL
ATTORNEY/CLIENT PRIVILEGE**

District Name:		School/Site:	
Name (Last, First, M.I.):		<input type="checkbox"/> Student <input type="checkbox"/> Non-Student	
Home Address: Street, City, State, Zip		Grade	<input type="checkbox"/> Male <input type="checkbox"/> Female Date of Birth
Home Phone No.:		Date of Incident:	Time:
Reported to:		Date Reported:	Time:

i.e. police, principal, teacher or district office

DETAILS OF INCIDENT

Exact Location of Incident	
Did incident involve other student(s) or non-student(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No	IF "YES," GIVE NAME(S):
DESCRIBE HOW THE INCIDENT OCCURRED IN DETAIL (ATTACH ADDITIONAL SHEET OR REPORT IF NECESSARY)	

WAS EQUIPMENT OR MACHINERY INVOLVED? (PLAYGROUND, INDUSTRIAL ARTS, ETC.) Yes No IF "YES," NOTE ANY DEFICIENCIES

WAS A RULE OR PROCEDURE VIOLATED? EXPLAIN (Include horseplay)

Full Name of Teacher, Teacher's Aide, etc., for injured student	Title of Person (Teacher, Aide, etc.)	Present at time of incident? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Witness	Address	Phone
		Status: <input type="checkbox"/> Teacher <input type="checkbox"/> Parent <input type="checkbox"/> Student <input type="checkbox"/> Statement Attached: <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Witness	Address	Phone
		Status: <input type="checkbox"/> Teacher <input type="checkbox"/> Parent <input type="checkbox"/> Student <input type="checkbox"/> Statement Attached: <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Witness	Address	Phone
		Status: <input type="checkbox"/> Teacher <input type="checkbox"/> Parent <input type="checkbox"/> Student <input type="checkbox"/> Statement Attached: <input type="checkbox"/> Yes <input type="checkbox"/> No
Parent/Guardian Name	Date/Time Contacted	

Parent Comments:

NATURE OF INJURY	INJURED PART OF BODY
<input type="checkbox"/> Abrasion <input type="checkbox"/> Fracture <input type="checkbox"/> Sprain <input type="checkbox"/> Concussion <input type="checkbox"/> Contusion <input type="checkbox"/> Cut <input type="checkbox"/> Dislocation <input type="checkbox"/> Internal <input type="checkbox"/> Other - Explain below:	<input type="checkbox"/> Left Side <input type="checkbox"/> Right Side <input type="checkbox"/> Abdomen <input type="checkbox"/> Arm <input type="checkbox"/> Back <input type="checkbox"/> Chest <input type="checkbox"/> Eye <input type="checkbox"/> Face <input type="checkbox"/> Finger <input type="checkbox"/> Foot <input type="checkbox"/> Hand <input type="checkbox"/> Head <input type="checkbox"/> Leg <input type="checkbox"/> Neck <input type="checkbox"/> Other pain/discomfort - Explain below:
First Aid Treatment Given:	Name of person who administered First Aid:

Disposition Return to Class Home Doctor 911/Hospital

Other Transported By:

REPORT PREPARED BY	TITLE	PHONE NUMBER	DATE PREPARED

SITE ADMINISTRATOR SIGNATURE

CONFIDENTIAL ATTORNEY/CLIENT PRIVILEGE