



## EWSD Student Accident Report

Name \_\_\_\_\_ If visitor, phone: \_\_\_\_\_  
Age \_\_\_\_\_ Grade \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_ Visitor address: \_\_\_\_\_  
School of attendance: EES    HIA    SUM    FOU    FLE    WES    EMS    ADL    EHS    CTE  
Classroom Teacher \_\_\_\_\_ Supervising Staff Member \_\_\_\_\_  
Other Adult Present \_\_\_\_\_  
Witnesses to Accident (list) \_\_\_\_\_  
\_\_\_\_\_  
Location of accident \_\_\_\_\_  
Description of accident (attach additional sheets if necessary) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Protective gear **required** during activity?    Yes    No  
Type of gear \_\_\_\_\_  
Protective gear worn?    Yes    No  
Injury sustained \_\_\_\_\_  
\_\_\_\_\_  
Treatment given (attach additional sheets if necessary) \_\_\_\_\_  
\_\_\_\_\_

### **Please check all that apply:**

Parent/Guardian contacted:    Yes    No    (No, please explain why) \_\_\_\_\_ Time \_\_\_\_\_  
Dismissed to parent/guardian:    Yes    No    Drove self    Time \_\_\_\_\_  
First aid only \_\_\_\_\_  
Referral to be seen by MD/Dentist today \_\_\_\_\_  
EMS/911 call \_\_\_\_\_  
Return to class \_\_\_\_\_  
Additional notes if necessary: \_\_\_\_\_  
\_\_\_\_\_

Treatment Provider	_____	_____	_____	_____
	Name	Title	Signature	Date
Person Completing the Form	_____	_____	_____	_____
	Name	Title	Signature	Date
Principal or Designee	_____	_____	_____	_____
	Name	Title	Signature	Date

**Fax completed form immediately to Central Office East**