

Perquimans County Schools Student Incident/Accident Report

Name Age

School Teacher Grade

Date Time Person Completing Report

Place of Incident	Nature of Incident/Emergency	Body Part
Bus <input type="checkbox"/>	Anaphylaxis <input type="checkbox"/>	Abdomen <input type="checkbox"/>
Classroom <input type="checkbox"/>	Back Injury <input type="checkbox"/>	Arm <input type="checkbox"/>
Hallway <input type="checkbox"/>	Dental Injury <input type="checkbox"/>	Back <input type="checkbox"/>
Lunchroom <input type="checkbox"/>	Eye Injury <input type="checkbox"/>	Chest <input type="checkbox"/>
Media Center <input type="checkbox"/>	Fracture <input type="checkbox"/>	Ear <input type="checkbox"/>
Office <input type="checkbox"/>	Head Injury <input type="checkbox"/>	Elbow <input type="checkbox"/>
PE Class/Gym <input type="checkbox"/>	Heat/Cold Related <input type="checkbox"/>	Eye <input type="checkbox"/>
Play/School Grounds <input type="checkbox"/>	Laceration/Cut <input type="checkbox"/>	Face <input type="checkbox"/>
Restroom <input type="checkbox"/>	Mental Health <input type="checkbox"/>	Foot <input type="checkbox"/>
Other <input type="text"/>	Respiratory <input type="checkbox"/>	Hand <input type="checkbox"/>
	Sprain/Strain <input type="checkbox"/>	Head <input type="checkbox"/>
	Other <input type="text"/>	Knee <input type="checkbox"/>
		Leg <input type="checkbox"/>
	Front <input type="checkbox"/>	Mouth <input type="checkbox"/>
	Back <input type="checkbox"/>	Nose <input type="checkbox"/>
	Right <input type="checkbox"/>	Teeth <input type="checkbox"/>
	Left <input type="checkbox"/>	Wrist <input type="checkbox"/>

Describe Incident and/or Injury

Cause of Injury

Corrective Action Taken (Use additional sheets if needed)

	Yes	No
Was blood or other body fluid present?		
Was the responder exposed to blood or body fluids?		
Was the responder wearing personal protective equipment?		
Was this an exposure Incident?		
Were the parents notified?		
Required immediate care by a physician/dentist/EMS?		
Did child lose 1/2 or more days of school?		
Additional Comments		
Signature of Persons completing form and/or First Responder		
Principal Signature		