

# Perquimans County Schools Guest/Non-Employee Incident/Accident Report

**Injured Party's Full Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Parent/Guardian Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **SSN:** \_\_\_\_\_ **Gender** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Date:** \_\_\_\_\_ **Time of Accident:** \_\_\_\_\_ **Site/School Accident Occurred:** \_\_\_\_\_

\*\*The information provided is accurate to the best of my knowledge. I understand this report is for record purposes only and does not constitute the admission of liability on the part of the school system or any employee thereof.

\_\_\_\_\_ *signature*                      \_\_\_\_\_ *date*

-----For Official Use Only-----

**Place of Incident**

**Nature of Incident/Emergency**

**Body Part Injured**

- \_\_\_ Bus # \_\_\_\_\_
- \_\_\_ Classroom
- \_\_\_ Hallway
- \_\_\_ Lunchroom
- \_\_\_ Media Center
- \_\_\_ Office
- \_\_\_ P.E. Class / Gym
- \_\_\_ Play/School Grounds
- \_\_\_ Restroom
- \_\_\_ Other \_\_\_\_\_

- \_\_\_ Anaphylaxis (Severe Allergic Reaction)
- \_\_\_ Back Injury
- \_\_\_ Dental Injury
- \_\_\_ Eye Injury
- \_\_\_ Fracture

- \_\_\_ Head Injury
- \_\_\_ Heat/Cold Related
- \_\_\_ Laceration/Cut
- \_\_\_ Mental Health
- \_\_\_ Respiratory
- \_\_\_ Sprain/Strain
- \_\_\_ Other \_\_\_\_\_

- \_\_\_ Abdomen
- \_\_\_ Ankle
- \_\_\_ Arm
- \_\_\_ Back
- \_\_\_ Chest
- \_\_\_ Ear
- \_\_\_ Elbow
- \_\_\_ Eye
- \_\_\_ Face
- \_\_\_ Foot
- \_\_\_ Hand
- \_\_\_ Head
- \_\_\_ Knee
- \_\_\_ Leg
- \_\_\_ Mouth
- \_\_\_ Nose
- \_\_\_ Teeth
- \_\_\_ Wrist

**Describe In Detail Incident and/or Injury:**

\_\_\_\_\_

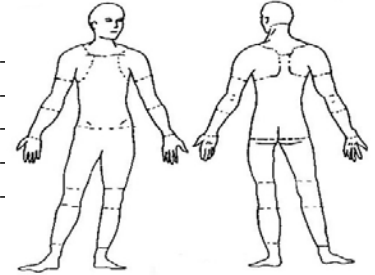
\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Body Part Affected:(shade injured area)**



**List of Witnesses to Accident/Incident:**

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Corrective Actions Taken (Use additional sheets if needed):

\_\_\_\_\_

\_\_\_\_\_

- Was the responder exposed to blood or body fluids?                      \_\_\_ Yes \_\_\_ No
- Was the responder wearing personal protective equipment?                      \_\_\_ Yes \_\_\_ No
- Required immediate care by a physician/dentist/EMS?                      \_\_\_ Yes \_\_\_ No

Signature of Person Completing Form: \_\_\_\_\_

Date: \_\_\_\_\_

Principal Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Finance Officer Signature: \_\_\_\_\_

Date: \_\_\_\_\_