FRANKLIN TOWNSHIP PUBLIC SCHOOLS
STUDENT ACCIDENT REPORT
(Please Print or Write Legibly)

NAME ___________________________________________ DOB _______ Age _______ HR _______ Grade _______ School _______

Bollinger Insurance: Yes _______ No _______
Insured: Basic _______ 24 Hour _______ Athletic _______

Address _______________________________________

Date _______ Time _______ am/pm _______ Place ___________________________________________

DESCRIPTION OF ACCIDENT (State specific activity engaged in when accident occurred. Specifically identify tools, instruments, objects involved.)

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

REPORTED BY: Student or Teacher (circle one) _______ TEACHER IN CHARGE ________________

Signature of Teacher ___________________________ Date ___________________________

NATURE OF INJURY (Identify specific part of body injured: right or left arm/leg, head, etc.)

________________________________________________________________________

________________________________________________________________________

FIRST AID TREATMENT (Administered by school nurse - if the nurse is not available, a qualified member of the staff may be designated by the principal to perform the duty.)

________________________________________________________________________

________________________________________________________________________

WAS 911 EMPLOYED? Yes _______ No _______ (If yes, report to Assist. Supt. for Business’s Office within 24 hours.)

AMBULANCE COMPANY ___________________________ HOSPITAL ___________________________

NOTIFICATION: Name of parent/guardian ___________________________ Phone: _______ Time: _______

RELEASED TO PARENT/GUARDIAN: ___________________________ Time: ___________________________

Signature of School Nurse or Principal: ___________________________ Date: ___________________________

FOLLOW-UP (1 week later if necessary)

________________________________________________________________________

If injured in interscholastic activities, when did the student return to active participation? ___________________________

________________________________________________________________________

Signature of School Nurse: ___________________________ Date: ___________________________

DISTRIBUTION:

Γ ORIGINAL TO ASSISTANT SUPERINTENDENT FOR BUSINESS

Γ Copy to Principal

Γ Copy Nurse's Office

Any other remarks or follow-up, please use the back of form.