LEON COUNTY SCHOOLS
STUDENT INCIDENT/ACCIDENT REPORT

LCS-9841-1102
Rev. 11/2010

Student Name:_____ Address:_____

_____

Age:_____ Sex:_____ School:_____ Grade:_____ Date:_____

Time_____ Who Reported Accident:_____

Location of Accident (gym, classroom, hall, cafeteria, etc.):_____

Describe Accident:_____

_____

_____

_____

Part of Body Injured: _____

Description of Injury:_____

Was First Aid Given? ☐ No Why? _____

☐ Yes By Whom?_____

Describe First Aid Care Administered:_____

_____

_____

_____

_____ _____

Signature of Person Who Administered First Aid Print Name

Outcome and Time:_____

☐ Back to Class
☐ Home
☐ Hospital via Ambulance
☐ Hospital via Parent/Guardian Transport
☐ Doctor's Office

Name and Address of Physician Handling Case:_____

_____

Parent or Guardian Notified? ☐ Yes How? _____ Date_____ Time_____

☐ No Why?_____

Witness(es) to Accident or Illness:

Name:_____ Address:_____

Phone:_____ Please submit statement.

Name:_____ Address:_____

Phone:_____ Please submit statement.

Name:_____ Address:_____

Phone:_____ Please submit statement.

_____ _____ _____ _____

Signature of Person Filing Report Print Name Position Date

_____ _____ _____

Signature of Principal Print Name Date

Copies to: ☐Student Clinic Record ☐Risk Management