

Flowing Wells School District
ACCIDENT REPORT

School: _____

Date of Report: _____

Time of Report: _____

a.m.
 p.m.

In all cases, this form should be filed through the school Health Office and signed by the Principal of the school.

Person Injured

Student Volunteer Age Sex Grade School Insurance

Name: _____ Employee Non-District Other Insurance

Address: _____ Phone: _____

Nature of Injury: _____

Accident

Date: _____ Time: _____ a.m. p.m. Location: _____

Description of Accident: _____

Witness(es)

Name of Person(s) on Duty/Witness(es): Official Position: Age: Address: Phone:

First Aid Rendered

Type of First Aid Administered: Person Administering: Time:

Parent/Relative Contacted

Name: Relationship to Injured: Time:

Sent Home Method of Transportation Time:
 Not Sent Home

Additional Information

Signature of Person Completing Report

Signature of Principal/Administrator

NOTE: The contents of this report do not constitute any admission of liability on the part of the school system or any employee thereof.