

# ACCIDENT REPORT

## DELL CITY INDEPENDENT SCHOOL DISTRICT

STUDENT'S NAME \_\_\_\_\_ DATE OF INJURY \_\_\_\_\_

TIME OF INJURY \_\_\_\_\_

GRADE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SS# \_\_\_\_\_

NATURE OF INJURY (DESCRIBE HOW THE INJURY OCCURRED):

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ACTION TAKEN:

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PERSONS NOTIFIED (CHECK THE ONES THAT APPLY):

\_\_\_\_ NURSE \_\_\_\_ PRINCIPAL \_\_\_\_ PARENT \_\_\_\_ OTHER: RELATIONSHIP \_\_\_\_\_

NURSE'S ASSESSMENT AND TREATMENT:

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NURSE'S RECOMMENDATION:

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NAME OF SUPERVISOR/TEACHER

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SIGNATURE OF SUPERVISOR/TEACHER

\_\_\_\_\_  
NAME OF NURSE

\_\_\_\_\_  
SIGNATURE OF NURSE

\_\_\_\_\_  
NAME OF PRINCIPAL

\_\_\_\_\_  
SIGNATURE OF PRINCIPAL