

School: _____ Date: _____

Siskiyou County Office of Education
609 South Gold Street
Yreka, CA 95557

1. This portion is to be completed by the district or certificated employee who witnessed and/or reported the accident. (If not witnessed, take statement from injured or other person who was present).

1. Student Name: _____ Grade: _____ Age: _____
Address: _____

2. Date & Time of Accident: _____

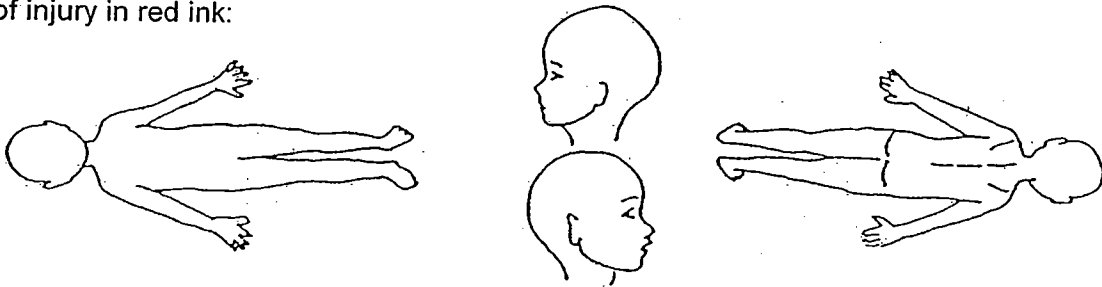
3. When Reported (Date & Time): _____

4. Where did the accident occur? Be specific: _____

5. Activity at time of accident: _____

6. Describe how the incident occurred and part of body injured (right/left) if applies:

7. "X" area of injury in red ink:



Witness(es) Name(s): _____

Reporting Employee Signature: _____



School: _____ Date: _____

II This portion is to be completed by School nurse or employee giving first aid

1. Observations and physical findings:

2. First Aid treatment:

3. Was student:

- | | | | |
|-----------------------|------------------------------|-----------------------------|----------------|
| a. Sent to office | <input type="checkbox"/> Yes | <input type="checkbox"/> No | By Whom: _____ |
| b. Seen by Nurse | <input type="checkbox"/> Yes | <input type="checkbox"/> No | By Whom: _____ |
| c. Returned to class | <input type="checkbox"/> Yes | <input type="checkbox"/> No | By Whom: _____ |
| d. Parent called | <input type="checkbox"/> Yes | <input type="checkbox"/> No | By Whom: _____ |
| e. Taken home | <input type="checkbox"/> Yes | <input type="checkbox"/> No | By Whom: _____ |
| f. Taken to Dr. _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No | By Whom: _____ |
| g. Taken to Hospital | <input type="checkbox"/> Yes | <input type="checkbox"/> No | By Whom: _____ |

4. Insurance Coverage: _____

5. Comments:

Signature of Person Completing Part II

Principal

This form must be faxed or mailed to the Special Schools & Services Department. **Serious accidents should also be reported by phone: 842.8432.**