

BISHOP ENGLAND HIGH SCHOOL ACCIDENT/INJURY REPORT

Location of Accident	Date of Accident	Time of Accident	Report Date	Injured Party
		AM/PM		<input type="checkbox"/> Student <input type="checkbox"/> Visitor <input type="checkbox"/> Other

Name of Injured: _____ Male Female Age/Date of Birth: _____

Parent/Guardian (If student): _____ Home/Cell Phone: _____

Work Phone: _____

Who was notified? Parent/Guardian Other: _____ (Name/Relation)

Injured Party was taken:

Home To physician To dentist To hospital Returned to class Other: _____

By Whom? _____ Time: _____ AM/PM

Nature of Accident	Injured Body Part	*					
<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Abrasion <input type="checkbox"/> Bruise <input type="checkbox"/> Burn <input type="checkbox"/> Concussion <input type="checkbox"/> Convulsion <input type="checkbox"/> Other </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Dental <input type="checkbox"/> Dislocation <input type="checkbox"/> Laceration <input type="checkbox"/> Puncture </td> </tr> </table>	<input type="checkbox"/> Abrasion <input type="checkbox"/> Bruise <input type="checkbox"/> Burn <input type="checkbox"/> Concussion <input type="checkbox"/> Convulsion <input type="checkbox"/> Other	<input type="checkbox"/> Dental <input type="checkbox"/> Dislocation <input type="checkbox"/> Laceration <input type="checkbox"/> Puncture	<table style="width: 100%; border: none;"> <tr> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Abdomen <input type="checkbox"/> Ankle* <input type="checkbox"/> Arm* <input type="checkbox"/> Back <input type="checkbox"/> Chest <input type="checkbox"/> Ear* </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Elbow* <input type="checkbox"/> Eye* <input type="checkbox"/> Face <input type="checkbox"/> Finger* <input type="checkbox"/> Foot* <input type="checkbox"/> Hand* </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Head <input type="checkbox"/> Knee* <input type="checkbox"/> Leg* <input type="checkbox"/> Teeth <input type="checkbox"/> Wrist* <input type="checkbox"/> Other </td> </tr> </table>	<input type="checkbox"/> Abdomen <input type="checkbox"/> Ankle* <input type="checkbox"/> Arm* <input type="checkbox"/> Back <input type="checkbox"/> Chest <input type="checkbox"/> Ear*	<input type="checkbox"/> Elbow* <input type="checkbox"/> Eye* <input type="checkbox"/> Face <input type="checkbox"/> Finger* <input type="checkbox"/> Foot* <input type="checkbox"/> Hand*	<input type="checkbox"/> Head <input type="checkbox"/> Knee* <input type="checkbox"/> Leg* <input type="checkbox"/> Teeth <input type="checkbox"/> Wrist* <input type="checkbox"/> Other	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both
<input type="checkbox"/> Abrasion <input type="checkbox"/> Bruise <input type="checkbox"/> Burn <input type="checkbox"/> Concussion <input type="checkbox"/> Convulsion <input type="checkbox"/> Other	<input type="checkbox"/> Dental <input type="checkbox"/> Dislocation <input type="checkbox"/> Laceration <input type="checkbox"/> Puncture						
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Describe the accident: _____

Describe the injury: _____

Was First Aid administered? Yes No If "Yes," by whom? _____

Describe First Aid given: _____

Signature of Person Preparing Report

Signature of Principal or Supervisor