

SAU 64
INCIDENT REPORT

Workers' comp ___
School insurance ___
Yes ___ No ___

INJURED PERSON _____

Student ___ staff ___ visitor ___

Age ___ Grade/position _____ School _____

Parent _____

Address _____

TIME AND PLACE OF INCIDENT

Date _____ Time _____

Location _____

Activity _____

Other persons involved _____

NATURE OF INJURY

- | | | |
|--------------------------------------|---------------------------------------------|-----------------------------------|
| <input type="checkbox"/> abrasion | <input type="checkbox"/> dental | <input type="checkbox"/> puncture |
| <input type="checkbox"/> bite | <input type="checkbox"/> orthopedic injury | <input type="checkbox"/> other |
| <input type="checkbox"/> bruise | <input type="checkbox"/> potential fracture | |
| <input type="checkbox"/> burn | <input type="checkbox"/> laceration | |
| <input type="checkbox"/> head injury | <input type="checkbox"/> eye injury | |

Injury to (indicate R,L)

- | | | | |
|--------------------------------|---------------------------------|--------------------------------|-----------------------------------|
| <input type="checkbox"/> ankle | <input type="checkbox"/> eye | <input type="checkbox"/> hip | <input type="checkbox"/> nose |
| <input type="checkbox"/> arm | <input type="checkbox"/> face | <input type="checkbox"/> knee | <input type="checkbox"/> shoulder |
| <input type="checkbox"/> back | <input type="checkbox"/> finger | <input type="checkbox"/> leg | <input type="checkbox"/> abdomen |
| <input type="checkbox"/> chest | <input type="checkbox"/> foot | <input type="checkbox"/> lip | <input type="checkbox"/> tooth |
| <input type="checkbox"/> elbow | <input type="checkbox"/> hand | <input type="checkbox"/> mouth | <input type="checkbox"/> wrist |
| <input type="checkbox"/> head | <input type="checkbox"/> neck | <input type="checkbox"/> other | |

CAUSE OF INJURY/INCIDENT

Describe how incident/injury occurred _____

Staff member witness _____

Other Witness _____

Mrs. Judith Nason, Chairperson
Mrs. Priscilla Colbath
Mrs. J. Lisbeth Olimpio
Mrs. Vivian Macedo
Mr. Stephen Brown

Adopted by the Board: 6 July 2005
Reaffirmed by the Board: 21 November 2012

ACTION/RESPONSE

Initial first aid _____
Provided by _____
Nurse Assessment _____

Nursing Intervention _____

DISPOSITION

___ Return to class
___ Refer to emergency room/hospital
 Name of hospital _____
 Transport by _____
___ Taken home by parent
___ Refer to physician by _____
___ Other (describe) _____

NOTIFICATION

___ Parent _____ Time _____
___ Other _____ Time _____
___ Person notifying _____

FOLLOW-UP TREATMENT

By (care provider) _____

Report by _____
Principal's signature _____
Date _____

Cc: SAU, nurse, principal, student health file

*Report needs to be forwarded to the SAU within 48 hours of the incident.

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