For Business Office Use Only		
Case Number:		
District / School:		

(over)

WAUNAKEE COMMUNITY SCHOOL DISTRICT MEDICAL INCIDENT / ACCIDENT REPORT

Directions:

In the event of an accident, significant illness or medical emergency in a school while an individual is under the direction of the district (field trips, extra-curricula activities) a Medical Incident / Accident Report should be completed by the supervising staff as soon as possible. It is imperative that the form be completed in detail, signed, dated and submitted to your direct supervisor within 24 hours.

<u>Injured or Ill Individual:</u> Last Name	First Name	M.I.	Sex Male Female
Student Position/Grade Level Employee Visitor		School/Building	
Home Address:			
Street	City	State	Zip
<u>Incident Information:</u> Date of Illness/Accident	Time of Illness/Accident	Illness/Accident Location (Building)	
mo. / day / yr.	hour / a.m. or p.m.		
First Adult Responder			
Name	Position	Building/School	
Witnesses to Onset of Illness o	-		
	Name and Title		
2	Name and Title		
3	Name and Title		

<u>Description of Injury and Location (check were appropriate):</u>

	G 47.1	N		
Anatomical Location	Cause of Injury	Nature of Injury	Location	Interscholastic
Abdomen	Animal	Abrasion	Athletic Field	Baseball
Ankle R L	Assault / Fight Chemical	Bite	Auditorium	Basketball Cheerleading/Dance
_ Arm R_L		Bruise / Bump	Auto/Bicycle	
—Back	_ Collision	— Burn	Auto/Pedestrian	Cross Country
Chest Collarbone	Drugs	Chip Concussion	Blacktop Cafeteria	Football Golf
	_ Electrical			
Ear R_L	Explosive	_Cut	Classroom	Gymnastics
Elbow RL	Fall / Slip	Drowning	Climbing Bars	Hockey
Eye RL_`	_Fire	Laceration	Field Trip	Soccer
Face	Hot Liquid	Poisoning	Golf Course	Swimming
Finger	Lifting	— Pull	Gym	Tennis
Foot_R_L_	Pencil/Pen	Puncture	Hallway	Track & Field
Hand R L	Poison	Scratch	Locker Room	Volleyball
Head	Running / Jumping	_ Shock	Parking Lot	Wrestling
Knee R_L_	Sharp Object	Sprain	Playground/field	
Leg_RL	Thrown Object	Wound	Pool	
Mouth	Other	Other	Restroom	
Neck			School Bus	
Nose			Maintenance Shop	
Ribs_R_L_			Sidewalk	
Shoulder R L			Stairs	
Tooth				
Other				
Action Takons				
Action Taken: YES NO		YES	NO	
	l sent to Health Office/Ath			treatment recommended
	l seen by nurse	ietic Trainei	EMS called	treatment recommended
	cy contacts notified			from medical practitioner
	l taken home		Sought treatment	nom medicai practitionei
	by whom?			
II yes,	by whom:			
Detailed Description of Ca	re Provided and Ry Whon	, .		
Detined Description of Ca	re i romaca ana by mon	<u> </u>		

Report Prepared By:					
· · · · · · · · · · · · · · · · · · ·	Name	Position/School	Date		
Administrator's Review:					
	Name	Position/School	Date		