STAFF/STUDENT ACCIDENT INVESTIGATION REPORT-SOUTH SIOUX CITY SCHOOLS

This form shall be completed by students/employees no later than 24 hours from the incident.

Name: _____ Building/Job assignment/Grade: _____

Person Completing Report*:_____

**Staff are to complete the report form directly in all cases, barring emergency exception*

Time Began Work/School Assignment: _____:_____

Date and time of Accident: _____/_____/_____ _____:_____

Date and time reported to Supervisor: _____/_____/_____ _____:_____

Where, exactly, did accident happen (location/room #/surroundings?) *Please be as descriptive as possible.*

_____

_____

What were you doing at the time? Describe step by step what led up to the accident (continue on the back if necessary): _____

_____

What was the root cause of the incident? (select all that apply)

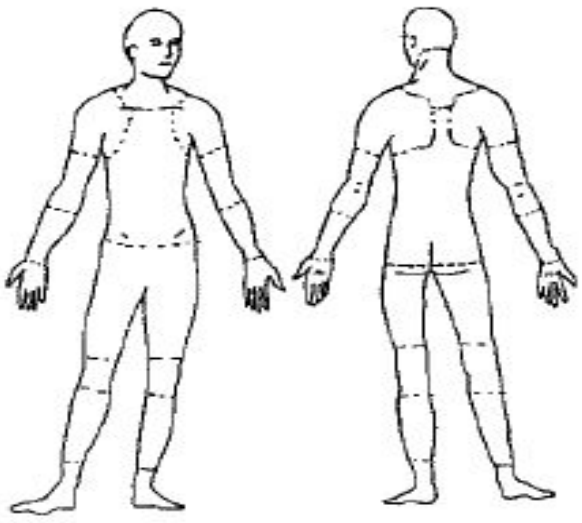
_____ slip/trip _____ equipment malfunction _____ overlooking surroundings

_____ environmental (ice/wet/etc) _____Other (please describe)_____

Witnesses (please list all):_____

_____

Specific Area of issue/injury:

Part of body affected: (shade/circle all that apply)	Nature of injury:	Area:
	_____Abrasion, scrapes _____ Amputation _____ Broken bone _____ Bruise _____ Burn (heat) _____ Burn (chemical) _____ Concussion (to the head) _____ Crushing Injury _____ Cut, laceration, puncture _____ Hernia _____ Illness _____ Sprain, strain _____ Damage to a body system _____ Other (please identify):____ _____	_____ Right _____ Left _____ Multiple/Other: Please describe: _____ _____ _____ _____

ADMINISTRATION/HR IS TO BE NOTIFIED IMMEDIATELY FOR ANY EXTERNAL MEDICAL CONSIDERATIONS

Is medical intervention/attention needed? _____Yes _____No

If yes, what type of medical intervention: _____ School Nurse/HC _____ External Clinic

_____ Urgent Care _____ ER _____ Other (Please identify)_____

Follow-up Care/Actions:

- **Internal:** School Nurse/Health Clerk/Staff Action (or N/A):_____

  _____

  Time/Date of initial assessment/action: _____/_____/_____ _____:_____

  Is additional follow-up/action needed? _____ Yes _____ No

  If yes, please describe:_____

- **External* (Contact Admin prior to scheduling):**

  Initial Appointment made/Visit Conducted: _____ Yes _____ No

  Doctor's name and phone number: _____

  Date and time of visit/appointment: _____/_____/_____ _____:_____

  Date Information/documentation shared with Admin.:_____

  ** If potential for expenses to be submitted for workers compensation/District liability coverage payment cannot be guaranteed, immediate notification to Admin. Is required.**

What could have been done to prevent this incident? _____

_____

Supervisor/Administrative Actions Taken to Address (including any maintenance/custodial work order):_____

_____

Supervisor Comments/Notes:_____

_____

Staff/Staff on behalf of (student) signature:_____ Date: _____/_____/_____

Supervisor/Bldg. Admin. Signature: _____ Date: _____/_____/_____

Student Svs. Director Signature(STUDENTS): _____ Date: _____/_____/_____

HR Signature (STAFF): _____ Date: _____/_____/_____

RETURN ORIGINAL DOCUMENTATION TO:

STAFF: Human Resources
STUDENTS: Director of Student Services
A copy may be provided to the staff member/student as requested.