

ACCIDENT REPORT FORM

Mercer County School District #404

This form is filled out for each accident that occurs in the school system by the instructor in charge (if an instructor was in charge) at the time of the accident.

Date of Report: _____

School: _____

Name of Injured: _____

Age: _____ Sex: _____

Student / Adult
(Circle one)

Address: _____

Location of Accident (building / grounds): _____

Date of Incident: _____

Time of Incident: _____

Description of how the injury occurred: _____

Supervising Instructor/ Report prepared by: _____

Other witnesses: _____

First Aid Given: _____

FILL OUT THIS PORTION IF INJURED IS A SCHOOL EMPLOYEE:

If medical treatment was given away from the worksite, list the name and address of the place it was given.

Please note if **Worker's Comp claim** needs to be initiated, and *notify the District Office immediately.*

Was the employee treated in an Emergency Room? Yes No

Was the employee hospitalized overnight as an inpatient? Yes No

Principal's Signature

School Nurse's Signature

Superintendent's Signature