

INDEPENDENT SCHOOL DISTRICT 196
Rosemount-Apple Valley-Eagan Public Schools
Educating our students to reach their full potential

Series Number 506.2.1.4P Adopted July 1980 Revised August 2013

Title Medical Incident Report for Students, Community Education Participants and Visitors

This form is to be completed by the District 196 staff person reporting the serious injury or illness of a district student, community education participant or visitor within 24 hours. Today's date _____

Student/Participant/Visitor _____ Gender M F Grade _____

School/Building _____ Date of incident ____/____/____ Time of incident _____ AM PM

Parent/Guardian name(s) _____

Address: _____ Phone number(s) _____
street city/state/zip

Part(s) of Body Involved (please circle R for right or L for left as appropriate)

- | | | | | | | |
|---|--------------------------------------|---------------------------------------|--|------------------------------------|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> abdomen/groin | <input type="checkbox"/> ankle (R/L) | <input type="checkbox"/> arm (R/L) | <input type="checkbox"/> back | <input type="checkbox"/> chest/rib | <input type="checkbox"/> ear (R/L) | <input type="checkbox"/> elbow (R/L) |
| <input type="checkbox"/> eye (R/L) | <input type="checkbox"/> face | <input type="checkbox"/> finger/thumb | <input type="checkbox"/> foot/toes (R/L) | <input type="checkbox"/> forehead | <input type="checkbox"/> hand (R/L) | <input type="checkbox"/> head/skull |
| <input type="checkbox"/> hip (R/L) | <input type="checkbox"/> knee (R/L) | <input type="checkbox"/> leg (R/L) | <input type="checkbox"/> mouth | <input type="checkbox"/> nose | <input type="checkbox"/> scalp | <input type="checkbox"/> side (R/L) |
| <input type="checkbox"/> shoulder (R/L) | <input type="checkbox"/> wrist (R/L) | <input type="checkbox"/> tooth | <input type="checkbox"/> other _____ | | | |

Nature of Injury/Illness

- | | | | | | | |
|---|---|------------------------------------|--|--------------------------------------|--------------------------------------|---|
| <input type="checkbox"/> abrasion/scratch | <input type="checkbox"/> amputation | <input type="checkbox"/> bite | <input type="checkbox"/> breathing | <input type="checkbox"/> bump/bruise | <input type="checkbox"/> burn | <input type="checkbox"/> choking |
| <input type="checkbox"/> dislocation | <input type="checkbox"/> electric shock | <input type="checkbox"/> fall/trip | <input type="checkbox"/> foreign body | <input type="checkbox"/> fracture | <input type="checkbox"/> head injury | <input type="checkbox"/> laceration/cut |
| <input type="checkbox"/> poisoning | <input type="checkbox"/> puncture | <input type="checkbox"/> scratches | <input type="checkbox"/> sprain/strain | <input type="checkbox"/> nosebleed | | |
| <input type="checkbox"/> other _____ | | | | | | |

Location of Injury/Incident

- | | | | | | | |
|---|--------------------------------------|------------------------------------|---|--|---|------------------------------------|
| <input type="checkbox"/> athletic field | <input type="checkbox"/> auditorium | <input type="checkbox"/> cafeteria | <input type="checkbox"/> classroom | <input type="checkbox"/> corridor/hall | <input type="checkbox"/> field trip | <input type="checkbox"/> gymnasium |
| <input type="checkbox"/> locker room | <input type="checkbox"/> pool | <input type="checkbox"/> restroom | <input type="checkbox"/> school grounds | <input type="checkbox"/> stairway | <input type="checkbox"/> to/from school | |
| <input type="checkbox"/> parking lot | <input type="checkbox"/> other _____ | | | | | |

Describe the injury/incident in detail: _____

How did the injury/incident occur? _____

What equipment/activity were involved with the injury/incident? _____

Action Taken and Follow Up

What, if any, first aid treatment was given? _____

First aid treatment provided by (name) _____ Position _____

Name of witness (if any) _____ Position _____

Name of parent notified _____ Time _____ AM PM Notified by _____

Time of transfer of care _____ AM PM Sent home with (name) _____

- sent to school nurse returned to class sent home physician referral 911 called

Follow-up report (doctor/clinic/hospital involved in treatment): _____

Person completing report/signature Title Date

Administrator signature Title Date

For a student, file in cumulative file

For a Community Education participant, file in appropriate Community Education office

For a visitor, file in school or building where the incident occurred