



Regional School District #17
Student/Visitor Report of Accident/Injury

Please complete this report and send to the building nurse immediately.

Name of Student/Visitor: _____ Grade/School: _____ Age: _____

Address: _____

Name & Address of Parent/Guardian: _____

Date of Accident: _____ Time: _____

Parent/Guardian Notified: Yes No Date and Time: _____

Was the area under supervision? Yes No

Staff on Duty: _____ Did they witness accident? Yes No

Cause of Accident: _____

Nature of Injury and Body Part Injured: _____

Attention Given to Injury by Staff: _____

Attention Given to Injury by School Nurse: _____

Is the student/visitor covered by "private" accident insurance? Yes No

Is the Student covered by "school time only" accident insurance? Yes No

Is the student covered by "around the clock" school accident insurance? Yes No

Is the student covered by the school system's "sports injury" insurance? Yes No

Printed Name & Signature of Person Reporting Accident: _____

Printed Name & Signature of Nurse: _____

Printed Name & Signature of Principal: _____

Copy to: parent/guardian, HR Benefit Specialist, Central Office