

Were efforts made to contact the parent/guardian about the accident? Yes No Time: _____

Was First Aid administered? Yes No

Were photos taken of injury and accident site? Yes No Who has Photos? _____

Was the student sent: Back to Class Home Physician Hospital

By whom (Name): _____

Witnesses (Name, Address, Phone): _____

IF MEDICAL OR HOSPITAL TREATMENT WAS REQUIRED, PLEASE COMPLETE THE FOLLOWING:

Name and address of doctor or hospital:

ACTION TAKEN TO PREVENT SIMILAR ACCIDENT

Check one or more

INSTRUCTIONAL:

Discussed at staff meeting Date: _____ Discussed in each class as part of regular instruction Date: _____

Discussed with parents Date: _____ Personal instruction given to person in charge Date: _____

Presented as a subject of assembly program Date: _____

POLICY OR CORRECTIVE ACTION:

Environment changes affected. Date: _____ Notified school safety committee. Date: _____

Safety rules amended to prevent recurrence. Date: _____ Supervision (training) Date: _____

District Safety Specialist and/or Facilities/Maintenance Ex Director invited to school to assist in safety program. Date: _____

OTHER:

No action taken, why:

Describe accident and injury in detail:

SIGNATURE OF TEACHER

SIGNATURE OF PRINCIPAL

Return completed form to: Jim Griner, Safety and Risk Coordinator, Wakulla County School District
Call the District Office Immediately If Accident Is Serious:
850.926.0065, #256, #257