OHIO DEPARTMENT OF HEALTH

STUDENT INJURY REPORT FORM

Student Information

Name: ________________________________ Date of Incident: ________________________

Grade: ________________________________ Time of Incident: ________________________

- ❑ Male ❑ Female

Parent/Guardian Information

Name(s): ____

Address: ____

Phone # Work: ____________________________ Home: ______________________________________

School Information

School: Vanlue Local School Phone #: (419) 387-7724

Principal: Robyn Hoadley Phone #: (419) 387-8103

District: Vanlue Local School

Location of Incident (check appropriate box):

- ❑ Athletic field
- ❑ Cafeteria
- ❑ Classroom
- ❑ Gymnasium
- ❑ Hallway
- ❑ Bus
- ❑ Stairway
- ❑ Restroom
- ❑ Playground
  - ❑ No equipment involved
  - ❑ Equipment involved (describe): ___________________________
    ____
- ❑ Parking lot
- ❑ Vocation/Shop lab
- ❑ Other (explain): ____

When Did the Incident Occur (check appropriate box):

- ❑ Recess
- ❑ Lunch
- ❑ P.E. class
- ❑ In class (not P.E.)
- ❑ Athletic practice/session:
- ❑ Athletic team competition
- ❑ Intramural competition
- ❑ Class change
- ❑ Field trip
- ❑ Before school
- ❑ After school
- ❑ Other __________________

Surface (check all that apply):

- ❑ Asphalt
- ❑ Carpet
- ❑ Concrete
- ❑ Dirt
- ❑ Gravel
- ❑ Ice/snow
- ❑ Lawn/grass
- ❑ Mat(s)
- ❑ Sand
- ❑ Wood chips/mulch
- ❑ Tile
- ❑ Synthetic surface
- ❑ Gymnasium floor
- ❑ Other ________________

Contributing Factors (check all that apply):

- ❑ Animal bite
- ❑ Collision with object
- ❑ Collision with person
- ❑ Compression/pinch
- ❑ Fall
- ❑ Fighting
- ❑ Overextension/twisted
- ❑ Foreign body/object
- ❑ Hit with thrown object
- ❑ Tripped/slipped
- ❑ Struck by object (bat, swing, etc.)
- ❑ Struck by auto, bike, etc.
- ❑ Contact with Hot or Toxic substance
- ❑ Drug, alcohol, or other substance involved
- ❑ Weapon
  Specify ______________________________
- ❑ Unknown
- ❑ Other __________________________________

Description of the Incident: ____

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Type of Injury (check all that apply):

	Head	Eye	Ear	Nose	Mouth/Lips	Tooth/Teet	Jaw	Chin	Neck/Throa	Collarbone	Shoulder	Upper Arm	Elbow	Forearm	Wrist	Hand	Finger	Fingernail	Chest/Ribs	Back	Abdomen	Groin	Genitals	Pelvis/Hip	Leg	Knee	Ankle	Foot	Toe
Abrasion/ Scrape																													
Bite																													
Bump/ Swelling																													
Bruise																													
Burn/Scald																													
Cut/ Laceration																													
Dislocation																													
Fracture																													
Pain/ Tenderness																													
Puncture																													
Sprain																													
Other																													

Witness(es) to the Incident: ____

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Staff Involved: ❑ Teacher ❑ Nurse ❑ Principal ❑ Assistant Staff ❑ Custodian
❑ Bus Driver ❑ Secretary ❑ Coach ❑ Advisor ❑ Other (specify) ____________

Incident Response (check all that apply):

❑ First Aid
Time: ____________ By Whom: ________________________

❑ Parent/Guardian Notified
Time: ____________ By Whom: ________________________

❑ Unable to contact Parent/Guardian
Time: ____________ By Whom: ________________________

❑ Returned to Class
Time: ____________ To What Class: ________________________

❑ Sent/Taken Home
Time: ____________ Picked Up By Whom: ________________________

❑ Called 9-1-1

❑ Taken to health care provider/clinic/hospital (emergency room)/urgent care
Diagnosis ________________________ Days of School Missed ____________

❑ Restricted School Activity
Explain ____
Length of Time Restricted ____________ Days of School Missed ____________

❑ Other ____

Describe Care Provided to the Student: ____

____

Additional Comments: ____

Signature of Staff Member Completing Form: ________________________ Date/Time ____________

Principal's Signature: ________________________ Date/Time ____________