

Forest Hills School District

Accident Report Form

(Please complete Sections I and II and send to the Treasurer's Office within 24 hours of incident)
(Section III must also be completed if the injured person is a FHSD employee)

SECTION I

Location of Accident:

- | | | |
|---|---|---|
| <input type="checkbox"/> Administration Building | <input type="checkbox"/> Maintenance Building | <input type="checkbox"/> Transportation Garage |
| <input type="checkbox"/> Anderson High School | <input type="checkbox"/> Mercer Elementary School | <input type="checkbox"/> Turpin High School |
| <input type="checkbox"/> Ayer Elementary School | <input type="checkbox"/> Nagel Middle School | <input type="checkbox"/> Wilson Elementary School |
| <input type="checkbox"/> Food Service/Transportation Building | <input type="checkbox"/> Sherwood Elementary School | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Maddux Elementary School | <input type="checkbox"/> Summit Elementary School | <input type="checkbox"/> Other: _____ |

General Information:

Name of injured person: _____ Date of Accident: _____
(First, Middle, Last Name)

Injured person: Student Employee (Complete Section I,II,III) Visitor Other: _____

Injured person's address: _____

Injured person's phone number: (____) _____ Date of Birth: _____ Sex: Male Female

Accident Information:

Time of Accident: _____ am pm Supervised Activity? Yes No (If yes, name of person in charge)

Name _____ Phone _____

Witnesses: Name / Phone _____ Name / Phone _____

Nature of Injury:

- | | | | | | |
|-----------------------------------|-------------------------------------|--------------------------------------|-------------------------------------|---------------------------------------|---------------------------------|
| <input type="checkbox"/> Abrasion | <input type="checkbox"/> Burn | <input type="checkbox"/> Cut | <input type="checkbox"/> Fracture | <input type="checkbox"/> Puncture | <input type="checkbox"/> Sprain |
| <input type="checkbox"/> Bruise | <input type="checkbox"/> Concussion | <input type="checkbox"/> Dislocation | <input type="checkbox"/> Laceration | <input type="checkbox"/> Other: _____ | |

Part of Body Injured:

- | | | | | | | |
|--|------------------------------------|---------------------------------------|---------------------------------------|-------------------------------|---------------------------------|---------------------------------------|
| Head: <input type="checkbox"/> Scalp | <input type="checkbox"/> Back | <input type="checkbox"/> Front | <input type="checkbox"/> Eye | <input type="checkbox"/> Ear | <input type="checkbox"/> Nose | <input type="checkbox"/> Mouth |
| <input type="checkbox"/> Teeth | <input type="checkbox"/> Neck | <input type="checkbox"/> Other: _____ | | | | |
| Trunk: <input type="checkbox"/> Chest | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Back | <input type="checkbox"/> Other: _____ | | | |
| Arms: <input type="checkbox"/> Shoulder | <input type="checkbox"/> Upper Arm | <input type="checkbox"/> Elbow | <input type="checkbox"/> Lower Arm | <input type="checkbox"/> Hand | <input type="checkbox"/> Finger | <input type="checkbox"/> Other: _____ |
| Legs: <input type="checkbox"/> Hip | <input type="checkbox"/> Upper Leg | <input type="checkbox"/> Knee | <input type="checkbox"/> Lower Leg | <input type="checkbox"/> Foot | <input type="checkbox"/> Toes | <input type="checkbox"/> Other: _____ |

Kind of Accident:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Animal/insect bite | <input type="checkbox"/> Collision with other person | <input type="checkbox"/> Fall or slip | <input type="checkbox"/> Contact with hot or toxic substance |
| <input type="checkbox"/> Fighting | <input type="checkbox"/> Struck by auto, bike, etc. | <input type="checkbox"/> Collision with object | <input type="checkbox"/> Other: _____ |

Where Accident Occurred:

- | | | | | | | |
|---|------------------------------------|---|--------------------------------------|---------------------------------------|-------------------------------------|-----------------------------------|
| <input type="checkbox"/> Athletic Field | <input type="checkbox"/> Cafeteria | <input type="checkbox"/> Classroom | <input type="checkbox"/> Gym | <input type="checkbox"/> Hallway | <input type="checkbox"/> Playground | <input type="checkbox"/> Restroom |
| <input type="checkbox"/> Bus | <input type="checkbox"/> Stairway | <input type="checkbox"/> To/From School | <input type="checkbox"/> Parking Lot | <input type="checkbox"/> Other: _____ | | |

Contributing Causes

- Environmental Factors:** (check only one)
- | | | | | | |
|-----------------------------------|--------------------------------------|--|---------------------------------------|---------------------------------|---------------------------------------|
| <input type="checkbox"/> Crowding | <input type="checkbox"/> Doors | <input type="checkbox"/> Drinking Fountain | <input type="checkbox"/> Equipment | <input type="checkbox"/> Floors | <input type="checkbox"/> Hard Surface |
| <input type="checkbox"/> Lighting | <input type="checkbox"/> No Handrail | <input type="checkbox"/> Weather | <input type="checkbox"/> Other: _____ | | |

Human Factors:

 (check only one)

- | | | | | | |
|--------------------------------------|---|---------------------------------------|------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Active Game | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Fighting | <input type="checkbox"/> Horseplay | <input type="checkbox"/> Lack of Training/Experience | <input type="checkbox"/> Preoccupied |
| <input type="checkbox"/> Running | <input type="checkbox"/> Violation of Rules | <input type="checkbox"/> Other: _____ | | | |

Agents:

 (check only one)

- | | | | | | |
|---|---|---------------------------------|----------------------------------|----------------------------------|---|
| <input type="checkbox"/> Animal or Insect | <input type="checkbox"/> Electricity | <input type="checkbox"/> Fire | <input type="checkbox"/> Gas | <input type="checkbox"/> Liquids | <input type="checkbox"/> Recreation Equipment |
| <input type="checkbox"/> Pencil/Pen | <input type="checkbox"/> School Equipment | <input type="checkbox"/> Solids | <input type="checkbox"/> Student | <input type="checkbox"/> Vehicle | |
| <input type="checkbox"/> Other: _____ | | | | | |

Accident Description: Describe the accident in your own words. Please give all details so that this accident report may be used to prevent other similar accidents. (Attach additional documentation if needed.)

SECTION II

Post Accident Report:

Was first aid given? Yes No If yes, by whom: _____
Was parent or other responsible person notified? Yes No If no, please explain: _____

Does health record indicate tetanus immunization currently effective? Yes No
Was injured person sent home? Yes No If yes, were they accompanied? Yes No
With whom were they accompanied? _____
Was injured person sent to physician? Yes No Name of physician: _____ Time: _____
Was injured person sent to a hospital? Yes No Name of hospital: _____ Time: _____
Days absent from school? (if applicable) _____

Date of Report: _____	Prepared By: _____	Position: _____
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Please send original to the Treasurer's Office. A copy should be sent to the building health office.

SECTION III - (Employee Accident Only)

Occupational Accident/Exposure

If accident or exposure occurred on employer's premises, give address and exact location where incident occurred. If accident occurred outside employer's premises at an identifiable address, give that address. If it occurred on a public highway or at any other place which cannot be identified by number and street, please provide references locating the place of injury as accurately as possible.

Place of accident or exposure (Street #, Street Name, City, State and Zip Code): _____

Date of Hire: _____ Social Security No. _____ - _____ - _____

Date reported to employer _____

Occupation (Regular Job Title): _____

Was place of accident or exposure on employer's premises? Yes No

Was anyone exposed to blood or body fluids as a result of the injury? Yes No

If yes, list those exposed: _____

Was a doctor or hospital notified that this was possibly a Workers' Compensation Claim? Yes No

If time from work is lost due to the accident, do you wish to use sick leave? Yes No

Employee chose not to see a doctor. Yes No Employee Signature: _____

Supervisor Comments: _____

As provided by Section 4123.651C of the Ohio Revised Code, I hereby permit the release of medical information, records and reports relative to the issues necessary for the administration of my workers' compensation claim to the Industrial Commission of Ohio, Ohio Bureau of Workers' Compensation, or the employer as such medical information, records and reports pertain to a condition either allowed or requested in my claim, or to consider the payment or to determine the eligibility of payment of compensation and medical benefits under my workers' compensation claim.

Employee Signature

Date

Supervisor Signature

Date

September, 2003