

# Standard School Incident Report

Risk Control from Liberty Mutual Insurance

*Date of Incident*

*Name of School*

*School District*

*Name of Injured Party*

*Address*

*Grade or Position*

☐ M ☐ F

*Age*

*Sex*

☐ AM ☐ PM

*Time of Incident*

It's important to get as much detail as possible about the incident being reported, but gather the information in an organized and easy to read form.

Names of witnesses and names of responders such as nurses, people calling an ambulance, people providing first aid, should all be recorded.

## Status

☐ Employee ☐ Student ☐ Visitor

☐ Trespasser ☐ Other (describe): \_\_\_\_\_

## Description of Incident

(How did the incident happen? What was the injured person doing? What tool, machine or equipment was involved? What teacher, supervisor or administrator was responsible for the area?)

## Who Witnessed the Incident? (List below)

*Witness One Name*

*Address*

*Phone*

*Witness Two Name*

*Address*

*Phone*

*Witness Three Name*

*Address*

*Phone*

### Location of Incident

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Athletic Field                   | <input type="checkbox"/> Bus                       | <input type="checkbox"/> Bus Stop           |
| <input type="checkbox"/> Cafeteria                        | <input type="checkbox"/> Classroom                 | <input type="checkbox"/> Gymnasium          |
| <input type="checkbox"/> Hallway                          | <input type="checkbox"/> Laboratory                | <input type="checkbox"/> Locker Room        |
| <input type="checkbox"/> Maintenance Area                 | <input type="checkbox"/> Office                    | <input type="checkbox"/> Off-Premises       |
| <input type="checkbox"/> Playground                       | <input type="checkbox"/> Restroom                  | <input type="checkbox"/> Sidewalk           |
| <input type="checkbox"/> Stairs ( <i>Inside</i> )         | <input type="checkbox"/> Stairs ( <i>Outside</i> ) | <input type="checkbox"/> Swimming Pool Area |
| <input type="checkbox"/> Theater or Stage                 | <input type="checkbox"/> Vocational Shops          |   |
| <input type="checkbox"/> Other ( <i>describe</i> ): _____ |  |   |

### Type of Injury

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Abrasion                         | <input type="checkbox"/> Amputation                       | <input type="checkbox"/> Asphyxiation             |
| <input type="checkbox"/> Bite ( <i>Animal or Insect</i> ) | <input type="checkbox"/> Bite ( <i>Human</i> )            | <input type="checkbox"/> Burn ( <i>Chemical</i> ) |
| <input type="checkbox"/> Burn ( <i>Heat</i> )             | <input type="checkbox"/> Concussion                       | <input type="checkbox"/> Dislocation              |
| <input type="checkbox"/> Electrical Shock                 | <input type="checkbox"/> Fracture                         | <input type="checkbox"/> Laceration               |
| <input type="checkbox"/> Poisoning                        | <input type="checkbox"/> Puncture                         | <input type="checkbox"/> Repetitive Motion        |
| <input type="checkbox"/> Sprain/Strain                    | <input type="checkbox"/> Other ( <i>describe</i> ): _____ |   |

### Body Part(s) Affected

- |                                  |   |                               |                                 |                                |
|----------------------------------|---|-------------------------------|---------------------------------|--------------------------------|
| <input type="checkbox"/> Abdomen | <input type="checkbox"/> Ankle                            | <input type="checkbox"/> Arm  | <input type="checkbox"/> Back   | <input type="checkbox"/> Chest |
| <input type="checkbox"/> Ear     | <input type="checkbox"/> Eye                              | <input type="checkbox"/> Face | <input type="checkbox"/> Finger | <input type="checkbox"/> Foot  |
| <input type="checkbox"/> Hand    | <input type="checkbox"/> Head                             | <input type="checkbox"/> Leg  | <input type="checkbox"/> Mouth  | <input type="checkbox"/> Tooth |
| <input type="checkbox"/> Wrist   | <input type="checkbox"/> Other ( <i>describe</i> ): _____ |                               |                                 |                                |

### Immediate Action Taken

- ☐ None
- ☐ First Aid provided      Given by: \_\_\_\_\_
- ☐ Medical Ambulance called:  
Time of Call: \_\_\_\_\_ By: \_\_\_\_\_
- ☐ School Nurse notified  
Time of Call: \_\_\_\_\_ By: \_\_\_\_\_
- ☐ Parent/Guardian notified  
Time of Call: \_\_\_\_\_ By: \_\_\_\_\_

## Parent or Guardian

\_\_\_\_\_  
*Parent/Guardian Name*

\_\_\_\_\_  
*Cell Phone*

\_\_\_\_\_  
*Home Phone*

\_\_\_\_\_  
*Work Phone*

## Injured Person Released to

☐ Self

☐ Home

☐ Class

☐ Physician

☐ Hospital

☐ Other: \_\_\_\_\_

Time Released: \_\_\_\_\_

☐ AM

☐ PM

## Notes

## Report Completed by

\_\_\_\_\_  
*Name*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Title*

\_\_\_\_\_  
*Phone Number*

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