

VISITOR ACCIDENT REPORT

To be completed immediately and sent to the Business Office.

School District: Independent School District #318 - Grand Rapids, MN	School or Building the Accident Occurred at:
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School Address:	School Phone Number:
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Visitor's Name:

Home Address:	Phone Number:
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Where did the accident occur?	Date & Time of Accident:
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How did the accident occur?

Name of Witnesses Present at Time of Accident:	Address:	Phone Number:
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Nature of Injury (Please Check):		Part of the Body Injured (Please Check): (Also Reference L=Left R=Right B=Both)					
Abrasion <input type="checkbox"/>	Cut <input type="checkbox"/>	Fracture <input type="checkbox"/>	Sprain <input type="checkbox"/>	Abdomen <input type="checkbox"/>	Chest <input type="checkbox"/>	Finger <input type="checkbox"/>	Knee <input type="checkbox"/>
Bruise/Bump <input type="checkbox"/>	Convulsion <input type="checkbox"/>	Laceration <input type="checkbox"/>		Ankle <input type="checkbox"/>	Elbow <input type="checkbox"/>	Foot <input type="checkbox"/>	Leg <input type="checkbox"/>
Burn <input type="checkbox"/>	Dislocation <input type="checkbox"/>	Puncture <input type="checkbox"/>		Arm <input type="checkbox"/>	Eye <input type="checkbox"/>	Hand <input type="checkbox"/>	Teeth <input type="checkbox"/>
Bruise/Bump <input type="checkbox"/>	Head Injury <input type="checkbox"/>	Shock <input type="checkbox"/>		Back <input type="checkbox"/>	Face <input type="checkbox"/>	Head <input type="checkbox"/>	Wrist <input type="checkbox"/>
Other _____		Other _____					

Was First Aid Applied? Yes <input type="radio"/> No <input type="radio"/>	By Whom?	Disposition of Injured (home, doctor, hospital):
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Additional Comments:

Report Submitted by:	Position:	Date:
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Principal or Director Signature:	Date:
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