



CONTRACTOR / VOLUNTEER / PARENT / VISITOR
ACCIDENT / ILLNESS / INJURY REPORT

This form must be submitted within 24 hours of the accident / illness / injury

Note: all Items and Sections noted in bold italics with an asterisk are required fields and MUST be completed

Submitter's FIRST Name: Submitter's LAST Name:

Phone Number: Email Address:

School / Building*:

Date of Accident* (m/d/y) Time of Accident* (use 24-hour clock e.g. 1:15 pm is 13:15)

Section ONE: LOCATION*

- Administration Office, Boot Room / Mud Room, Classroom, Concession / Cafeteria, Creative Playground, CTS Lab, Drama / Arts / Theatre, Exterior Stairs, Gymnasium, Hallway / Stairwell, In Transit to or from School, Locker Room, Off-Site, Playing Field, Science Lab, Sidewalk, Staff Parking Lot, Student Parking Lot, Tarmac, Washroom, Other (specify)

If Off-Site, State FACILITY Name:

Address:

City: Postal Code:

Section TWO: ACCIDENT / INCIDENT INFORMATION* Description of Accident / Incident (detailed narrative)

Blank lines for detailed narrative description of the accident or incident.

First Reported to FIRST Name: LAST Name:

- Area Director, Caretaking / Facility Operator, Contractor, Lunch / Playground Supervisor, Non School based Department Head, Principal, Secretary / Support Staff, Other (specify), Superintendent, Support Counsellor, Teacher, Team Leader, Vice / Assistant Principal, Volunteer

Supervisor FIRST Name: LAST Name:

- Area Director, Caretaking / Facility Operator, Contractor, Other (specify), Lunch / Playground Supervisor, Non School Based Department Head, Principal, Secretary / Support Staff, Support Counsellor, Teacher, Team Leader, Vice / Assistant Principal, Volunteer

Program*

- Before / After School, Field Trip, Interscholastic Game / Practice, Intramurals, Physical Education, Recess / Noon Hour, Regular Classroom, School Activity / Event (ie. play day), School Assembly, Science Lab, Spare / Free Time / Study Period, Other (specify), Transition between Classes, Work Study



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Equipment Involved (if applicable)

- Athletic Equipment, Art Equipment, Box Horses, Chemicals, Flying Fox, Gymnastic Equipment, Home Economic Equipment, In-Line Skates, Monkey Bars, Other Playground Equipment, Science Lab Equipment, Shop Tools, Scooters, Slide, Swing, Teeter Totter, Tetherball, Track & Field Equipment

Action(s) taken to prevent this sort of accident from happening in the future

CHECK if media has been involved or likely to be involved CHECK if legal action has been threatened Record number of people involved

Section THREE: INVOLVED PERSON*

FIRST Name*: _____ LAST Name*: _____

Phone Number: _____ Email Address: _____

Gender of Person Involved*: Male Female Unknown Date of Birth* (m/d/y)

Name of Employer (if contractor): _____

Activity*

- Administration, Caretaking, Classroom Preparation, Concession Duties, Delivery / Transportation, Field Trip, General Office / School Work, Handling / Moving Equipment, Books or Materials, Instruction, Leaving / Entering School Grounds, Maintenance / Grounds Work, Other (specify), Participate in Intramural Sports, Restraint of Student, Supervision, Walking, Working with / Assisting Special Needs Student

Accident / Incident Details*

Was this Person Injured? Yes No Was First Aid Administered? Yes No

If First Aid was administered, complete name of First Aider FIRST Name*: _____ LAST Name*: _____

Description of First Aid Administered

Qualified District First Aider? Yes No

First Aid Qualification Advanced Emergency Nurse Standard Wilderness

Was a paramedic or Physician Called? Yes No If Yes, was an Ambulance used? Yes No

Provide name of physician or hospital _____

If no ambulance was used, identify method of transportation _____

If pre-existing medical condition exists, give details below, and diagnosis if available _____

Did this person lose time from work? (required for Volunteer injury) Yes No First day of lost time (m/d/y)



Injury / Illness Type* (check as many that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Allergic reaction | <input type="checkbox"/> Fainting, loss of consciousness | <input type="checkbox"/> Permanent disability |
| <input type="checkbox"/> Back / Spinal injury | <input type="checkbox"/> Fatality | <input type="checkbox"/> Seizure (ambulance called) |
| <input type="checkbox"/> Bad scrape | <input type="checkbox"/> Irritation of eye / Skin | <input type="checkbox"/> Seizure (short term – no ambulance called) |
| <input type="checkbox"/> Breathing difficulties / Asthma (no ambulance called) | <input type="checkbox"/> Laceration (required stitches or medical attention) | |
| <input type="checkbox"/> Broken bone(s) with long term affects (surgery required, pins or plates inserted) | <input type="checkbox"/> Serious breathing difficulties (ambulance called) | |
| <input type="checkbox"/> Broken or fractured bones | <input type="checkbox"/> Minor aches / Pains | <input type="checkbox"/> Serious / Major bleed, bruise or swelling |
| <input type="checkbox"/> Chemical or other hazardous material contact | <input type="checkbox"/> Minor cut / Laceration / Irritation | <input type="checkbox"/> Severe sprain |
| <input type="checkbox"/> Concussion (possible concussion) | <input type="checkbox"/> Minor scrape or bump | <input type="checkbox"/> Severe wound (scarring or surgery) |
| <input type="checkbox"/> Dislocated / Separated joint | <input type="checkbox"/> Minor swelling or bruising | <input type="checkbox"/> Sprain |
| <input type="checkbox"/> Dizziness / Headache / Nausea | <input type="checkbox"/> Muscle pull or strain | <input type="checkbox"/> Tooth / Teeth injury |
| <input type="checkbox"/> Other (specify) _____ | | |

Cause of Injury* (check as many that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Accidental collision between participants | <input type="checkbox"/> Carelessness on the part of the individual | <input type="checkbox"/> Repetitive strain |
| <input type="checkbox"/> Aggravation of pre-existing injury | <input type="checkbox"/> Fall / Trip not due to observed factor | <input type="checkbox"/> Site hazard |
| <input type="checkbox"/> Assault | <input type="checkbox"/> Fall or loss of balance on apparatus | <input type="checkbox"/> Slip / Fall (ice) |
| <input type="checkbox"/> Bite (animal / human / insect) | <input type="checkbox"/> Motor vehicle accident | <input type="checkbox"/> Slip / Fall (other) |
| <input type="checkbox"/> Blow / Hit / Trip caused by another person, accidental or intentional | <input type="checkbox"/> No clear apparent cause | <input type="checkbox"/> Strain or over exertion |
| <input type="checkbox"/> Blow delivered by an object (ball, bat, etc.) | <input type="checkbox"/> Obstruction on playing field | <input type="checkbox"/> Working with / assisting special needs students |
| <input type="checkbox"/> Body contact in the normal course of activity | | |
| <input type="checkbox"/> Other (specify) _____ | | |

Body Part* (check as many that apply)

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Abdomen / Stomach | <input type="checkbox"/> Elbow | <input type="checkbox"/> Lower arm | <input type="checkbox"/> Teeth |
| <input type="checkbox"/> Ankle | <input type="checkbox"/> Eye(s) | <input type="checkbox"/> Lower leg / Calf | <input type="checkbox"/> Toes |
| <input type="checkbox"/> Back | <input type="checkbox"/> Finger(s) / Thumb | <input type="checkbox"/> Mouth | <input type="checkbox"/> Upper arm |
| <input type="checkbox"/> Buttocks | <input type="checkbox"/> Foot | <input type="checkbox"/> N/A | <input type="checkbox"/> Upper leg / Thigh |
| <input type="checkbox"/> Cheek(s) | <input type="checkbox"/> Groin | <input type="checkbox"/> Neck / Throat | <input type="checkbox"/> Wrist |
| <input type="checkbox"/> Chest Area | <input type="checkbox"/> Hand | <input type="checkbox"/> Nose | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Chin | <input type="checkbox"/> Head | <input type="checkbox"/> Possible internal injuries | |
| <input type="checkbox"/> Collarbone | <input type="checkbox"/> Hip | <input type="checkbox"/> Shoulder | |
| <input type="checkbox"/> Ear(s) | <input type="checkbox"/> Knee | <input type="checkbox"/> Side / Ribs | |
| | | | |

- If there are **multiple involved persons** (student, employee or other) associated with this event, complete **SECTION THREE (3)** of the appropriate / respective injury form for each involved person and attach to this report
- If there is a **hazard** associated with this injury complete a **HAZARD FORM** and attach to this report

Section FOUR: WITNESS* (Use separate sheet if more than one witness)

Were there any witnesses*? Yes No

Witness FIRST Name: _____ **Witness LAST Name:** _____

Address / City / Postal Code: _____

Phone Number: _____

WITNESS ROLE

- | | | | | |
|-------------------------------------|-----------------------------------|------------------------------------|-------------------------------------|------------------------------------|
| <input type="checkbox"/> Bystander | <input type="checkbox"/> Daycare | <input type="checkbox"/> Neighbour | <input type="checkbox"/> Student | <input type="checkbox"/> Volunteer |
| <input type="checkbox"/> Contractor | <input type="checkbox"/> Employee | <input type="checkbox"/> Parent | <input type="checkbox"/> Supervisor | |

Date of Report: _____

Report Approved by: _____

Position: _____
(print clearly)