



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*

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Administration office | <input type="checkbox"/> CTS Lab | <input type="checkbox"/> In transit to or from school | <input type="checkbox"/> Sidewalk |
| <input type="checkbox"/> Boot room / Mud room | <input type="checkbox"/> Drama / Arts / Theatre | <input type="checkbox"/> Locker room | <input type="checkbox"/> Staff parking lot |
| <input type="checkbox"/> Classroom | <input type="checkbox"/> Exterior stairs | <input type="checkbox"/> Off-Site | <input type="checkbox"/> Student parking lot |
| <input type="checkbox"/> Concession / Cafeteria | <input type="checkbox"/> Gymnasium | <input type="checkbox"/> Playing field | <input type="checkbox"/> Tarmac |
| <input type="checkbox"/> Creative playground | <input type="checkbox"/> Hallway / Stairwell | <input type="checkbox"/> Science lab | <input type="checkbox"/> Washroom |
| <input type="checkbox"/> Other (specify) _____ | | | |

If Off-Site, State FACILITY Name: _____

Address: _____

City: _____ **Postal Code:** _____

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

First Reported to **FIRST Name:** _____ **LAST Name:** _____

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Area Director | <input type="checkbox"/> Principal | <input type="checkbox"/> Support Counsellor | <input type="checkbox"/> Vice / Assistant Principal |
| <input type="checkbox"/> Caretaking / Facility Operator | <input type="checkbox"/> Secretary / Support Staff | <input type="checkbox"/> Teacher | <input type="checkbox"/> Volunteer |
| <input type="checkbox"/> Lunch / Playground Supervisor | <input type="checkbox"/> Superintendent | <input type="checkbox"/> Team Leader | |
| <input type="checkbox"/> Non School based Department Head | <input type="checkbox"/> Other (specify) _____ | | |

Supervisor **FIRST Name:** _____ **LAST Name:** _____

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Area Director | <input type="checkbox"/> Non School Based Department Head | <input type="checkbox"/> Support Counsellor | <input type="checkbox"/> Vice / Assistant Principal |
| <input type="checkbox"/> Caretaking / Facility Operator | <input type="checkbox"/> Principal | <input type="checkbox"/> Teacher | <input type="checkbox"/> Volunteer |
| <input type="checkbox"/> Lunch / Playground Supervisor | <input type="checkbox"/> Secretary / Support Staff | <input type="checkbox"/> Team Leader | |
| <input type="checkbox"/> Other (specify) _____ | | | |

Program*

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

Equipment Involved (if applicable)

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Art Equipment | <input type="checkbox"/> Flying Fox | <input type="checkbox"/> Monkey Bars | <input type="checkbox"/> Shop Tools |
| <input type="checkbox"/> Athletic Equipment | <input type="checkbox"/> Gymnastic Equipment | <input type="checkbox"/> Other Playground Equipment | <input type="checkbox"/> Track & Field Equipment |
| <input type="checkbox"/> Box Horses | <input type="checkbox"/> Home Economic Equipment | <input type="checkbox"/> Science Lab Equipment | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Chemicals | <input type="checkbox"/> In-Line Skates | <input type="checkbox"/> Scooters | |



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 Date of Birth* (m/d/y) _____

Employee ID: _____ Job Position: _____

Status* Caretaking Certificated Staff Exempt Staff Support Staff Trades Other (specify)

Activity*

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

Is this a workplace violence issue? Yes No

If this is a workplace violence issue, please check parties involved:

Parties Involved Student to Staff Staff to Staff Parent to Staff Volunteer to Staff Other (specify)

Covered by WCB? Yes No Is there a current Hazard assessment for this position? Yes No

Has current assessment been reviewed? Yes No

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*? Yes No First day of lost time (m/d/y) _____

Duties modified after accident? Yes No

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

- Checkboxes for injury types: Allergic reaction, Back / Spinal injury, Bad scrape, Breathing difficulties / Asthma, Broken bone(s) with long term affects, Broken or fractured bones, Chemical or other hazardous material contact, Concussion, Dislocated / Separated joint, Dizziness / Headache / Nausea, Fainting, loss of consciousness, Fatality, Irritation of eye / Skin, Laceration, Minor aches / Pains, Minor cut / Laceration / Irritation, Minor scrape or bump, Minor swelling or bruising, Muscle pull or strain, Permanent disability, Seizure (ambulance called), Seizure (short term - no ambulance called), Serious breathing difficulties, Serious / Major bleed, bruise or swelling, Severe sprain, Severe wound, Sprain, Tooth / Teeth injury, Other (specify)

Cause of Injury* (check as many that apply)

- Checkboxes for cause of injury: Accidental collision between participants, Aggravation of pre-existing injury, Assault, Bite, Blow / Hit / Trip caused by another person, Blow delivered by an object, Body contact in the normal course of activity, Carelessness on the part of the Individual, Fall / Trip not due to observed factor, Fall or loss of balance on apparatus, Motor vehicle accident, No clear apparent cause, Obstruction on playing field, Repetitive strain, Site hazard, Slip / Fall (ice), Slip / Fall (other), Strain or over exertion, Working with assisting special needs Students, Other (specify)

Body Part* (check as many that apply)

- Checkboxes for body parts: Abdomen / Stomach, Ankle, Back, Buttocks, Cheek(s), Chest Area, Chin, Collarbone, Ear(s), Elbow, Eye(s), Finger(s) / Thumb, Foot, Groin, Hand, Head, Hip, Knee, Lower Arm, Lower leg / Calf, Mouth, N/A, Neck / Throat, Nose, Possible internal injuries, Shoulder, Side / Ribs, Teeth, Toes, Upper arm, Upper leg / Thigh, Wrist, Other (specify)

- 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

- Checkboxes for witness roles: Bystander, Contractor, Daycare, Employee, Neighbour, Student, Supervisor, Volunteer

Date of Report: _____

Report Approved by: _____

Position: _____ (print clearly)