



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*: _____

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

Supervisor's **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)

- Equipment options: 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, Other (specify)

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*, Grade*

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

Activity*

- Activity options: Assembly, Baseball / Softball, Basketball, Canoeing, Kayaking, Rafting, Class Change / Transition, Class or Shop Activities, Curling, Dance, Dodge Ball, Field Hockey, Floor Hockey, Football (reg. touch), Football (tackle), Free Play / Recess / Noon Hour, Gymnastics, Ice Sports - Hockey / Skating, In-Line Skating, Intramural Sports, Lacrosse, Physical Ed / Active Living, Racquet Games, Rollerblading, Rugby, School Activity, Skiing / Snowboarding, Soccer, Study Period / Free Time, Swimming / Water Sports, Track & Field, Walking / Running, Weight Room Training, Work Experience, Wrestling, Other (specify)

Accident / Incident Details

Was this Person Injured*?, Was First Aid Administered*?

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

Parent's First Name, Parent's Last Name

Were the parents notified*? Yes/No, Date notified (m/d/y), Time Notified (2400 hr. clock)

Parent's Comments:

Did parent pick up child? Yes/No



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

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

Date of Report: _____

Report Approved by: _____
(print clearly)

Position: _____
(print clearly)