DURAND AREA SCHOOLS
310 North Saginaw Street • Durand, MI 48429

REPORT OF INJURY

SCHOOL:_____ TYPE OF INJURY: ☐Student ☐Sport ☐Employee

NAME:_____ ADDRESS:_____

PHONE: (____)_____ GRADE:_____ D.O.B.:_____ GENDER:____

PLACE OF INJURY:_____ DATE/TIME OCURRED:_____

PART(S) OF BODY INJURED:_____
(please indicate right/left side, exact location, etc.)

DESCRIBE FULLY HOW INJURY HAPPENED:_____

_____

(continue on back if necessary)

PERSON WHO TOOK INITIAL CARE OF INJURY:_____ SCHOOL EMPLOYEE? ☐Yes ☐No

ACTION TAKEN:_____

WITNESS(ES):_____

DATE INJURY REPORTED:_____ REPORTED TO?_____

DID INJURY REQUIRE THE CARE OF A PHYSICIAN? ☐Yes ☐No	HOSPITAL? ☐Yes ☐No
NAME OF PHYSICIAN:	NAME OF HOSPITAL:
ADDRESS:	WERE YOU HOSPITALIZED OVERNIGHT?

FOLLOW-UP (days lost from school/work, hospitalized, under doctor's care, sutures, etc., if known) _____

_____

_____

REPORT PREPARED BY:_____ POSITION:_____

BUILDING ADMINISTRATOR SIGNATURE:_____ DATE:_____

EMPLOYEE ACCIDENT ONLY: PLEASE FILL OUT ADDITIONAL INFORMATION

DID YOU STOP WORKING AS A RESULT OF YOUR INJURY? ☐Yes ☐No WHEN?_____

NAME/ADDRESS OF PHYSICIAN TREATING YOU:_____

PHYSICIAN FOLLOW-UP NEEEDED? ☐Yes ☐No WHEN?_____

OTHER CARE RECEIVED FOR THIS INJURY:_____

_____

NUMBER OF DAYS LOST FROM WORK:_____

NUMBER OF DAYS OF RESTRICTED ACTIVITY ON JOB:_____

JOB TITLE/BUILDING ASSIGNMENT:_____

SOCIAL SECURITY NUMBER:_____

This form must be forwarded to the Board of Education office within two (2) days of incident.

6/25/09