

## STUDENT ACCIDENT REPORT

Complete this form in duplicate and submit one copy within 48 hours of the accident to the Secretary-Treasurer. Retain a copy for your files.

School or Department: \_\_\_\_\_ Transportation Services Only:  
Route # \_\_\_\_\_

Student's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Male Female

Student's Address: \_\_\_\_\_

Name of Parent or Guardian: \_\_\_\_\_

Staff Member in Charge of Student: \_\_\_\_\_

Date and Hour of Accident: \_\_\_\_\_

Student's Course or Program During Which Accident Occurred: \_\_\_\_\_

Provide Complete Details of the Accident below, include the name of any witnesses:

Indicate Nature of the Injury: \_\_\_\_\_

Indicate Treatment Provided  
at the Time: \_\_\_\_\_

Notification	Name of Parent, Guardian, or Emergency Contact	Date and Time	Name of Staff Member who notified Contact	Staff Member Initials
If no parental contact was made explain why in "Other Comments"				

Other Comments (follow-up diagnosis, treatment, notification, etc.)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Supervising Staff member

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Principal