

Student Injury Report Form Guidelines

The Ohio Department of Health (ODH) provides the following Student Injury Report Form and guidelines as an example for districts to use in tracking the occurrence of school-related injuries. ODH suggests completing the form when an injury leads to any of the following:

- 1. The student misses ½ day or more of school.**
- 2. The student seeks medical attention (health care provider office, urgent care center, emergency department).**
- 3. EMS 9-1-1 is called.**

Schools are encouraged to review and use the information collected on the injury report form to influence local policies and procedures as needed to remedy hazards.

Instructions

- Student, parent and school information: self-explanatory.
- Check the box to indicate the location and time the incident occurred.
- Check the box to indicate if equipment was involved; describe involved equipment. Indicate what type of surface was present where the injury occurred.
- Using the grid, check the body area(s) where the student was injured and indicate what type of injury occurred. Include all body areas and injuries that apply.
- Check the appropriate box(es) for factors that may have contributed to the student's injury.
- Provide a detailed description of the incident. Indicate any witnesses to the event and any staff members who were present. Attach another sheet if more room is needed.
- Incident response: include all areas that apply.
- Provide any further comments about this incident, including any suggestions for what might prevent this type of incident in the future.
- Sign the completed form.
- Route the form to the school nurse and the principal for review/signature.
- Original form and copies should be filed according to district policy.

Ohio Department of Health Student Injury Report

Student information

Name		Date of incident	
Date of birth	Grade	<input type="checkbox"/> Male <input type="checkbox"/> Female	Time of incident

Parent/guardian information

Name(s)		Work phone ()	
Address		Home phone ()	
City	State	ZIP	Cell phone ()

School information

School	Phone ()
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Location of incident check appropriate box

- Athletic field Cafeteria Gymnasium Parking lot Restroom Vocation shop/lab
 Bus Classroom Hallway Playground Stairway
 Other *explain*

Time of incident check appropriate box

- Recess Lunch P.E. class In class (not P.E.) Class change Field trip
 Before school After school Unknown
 Other *explain*

Athletic practice/session:

- Athletic team competition Intramural competition

Equipment

- No equipment involved Equipment involved *describe*

Surface check all that apply

- Asphalt Concrete Gravel Ice/snow Mat(s) Synthetic surface Wood chips/mulch
 Carpet Dirt Gymnasium floor Lawn/grass Sand Tile
 Other *specify*

Type of injury check all that apply

	Head	Eye	Ear	Nose	Mouth/lips	Tooth/teeth	Jaw	Chin	Neck/throat	Collarbone	Shoulder	Upper arm	Elbow	Forearm	Wrist	Hand	Finger	Fingernail	Chest/ribs	Back	Abdomen	Groin	Genitals	Pelvis/hip	Leg	Knee	Ankle	Foot	Toe
Abrasion/scrape																													
Bite																													
Bump/swelling																													
Bruise																													
Burn/scald																													
Cut/laceration																													
Dislocation																													
Fracture																													
Pain/tenderness																													
Puncture																													
Sprain																													
Other																													

Contributing factors *check all that apply*

- | | | | | |
|--|--|---|---|--|
| <input type="checkbox"/> Animal bite | <input type="checkbox"/> Compression/pinch | <input type="checkbox"/> Fall | <input type="checkbox"/> Overextension/twisted | <input type="checkbox"/> Struck by object (bat, swing, etc.) |
| <input type="checkbox"/> Collision with object | <input type="checkbox"/> Contact with hot or toxic substance | <input type="checkbox"/> Foreign body/object | <input type="checkbox"/> Physical Altercation | <input type="checkbox"/> Tripped/slipped |
| <input type="checkbox"/> Collision with person | <input type="checkbox"/> Drug, alcohol or other substance involved | <input type="checkbox"/> Hit with thrown object | <input type="checkbox"/> Struck by auto, bike, etc. | |
| <input type="checkbox"/> Weapon <i>specify</i> | | <input type="checkbox"/> Other <i>explain</i> | | |

Description of the incident

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Witnesses to the incident

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Staff involved *check all that apply*

- | | | | | |
|--|--|------------------------------------|------------------------------------|---|
| <input type="checkbox"/> Assistant staff | <input type="checkbox"/> Cafeteria staff | <input type="checkbox"/> Nurse | <input type="checkbox"/> Secretary | <input type="checkbox"/> Other <i>specify</i> |
| <input type="checkbox"/> Bus driver | <input type="checkbox"/> Custodian | <input type="checkbox"/> Principal | <input type="checkbox"/> Teacher | |

Incident response *check all that apply*

<input type="checkbox"/> First Aid	Time	By whom	
<input type="checkbox"/> Called 911	Time	By whom	
<input type="checkbox"/> Parent/guardian notified	Time	By whom	
<input type="checkbox"/> Unable to contact parent/guardian	Time	By whom	
<input type="checkbox"/> Parents deemed no medical action necessary	<input type="checkbox"/> Returned to class	<input type="checkbox"/> Sent/taken home	Days of school missed
<input type="checkbox"/> Taken to health care provider / clinic/hospital/urgent care	Diagnosis		Days of school missed
<input type="checkbox"/> Hospitalized	Diagnosis		Days of school missed
<input type="checkbox"/> Restricted school activity	Explain	Length of time restricted	Days of school missed
<input type="checkbox"/> Other <i>explain</i>			

Describe care provided to the student

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Additional comments

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Signature of staff member completing form	Date/time
Nurse's signature	Date/time
Principal's signature	Date/time