

**East Guernsey Local School District
Staff Injury Report**

Name: _____ **Date of Injury:** _____

Time of Injury: _____ AM or PM

Have you told your supervisor about this injury? ___ Yes ___ No **Date Reported** _____

Witnesses:

Name: _____

Name: _____

Name: _____

Exact Location Injury Occurred: _____

Describe the circumstances causing the injury: _____

Contributing Factors (check all that apply):

- Fall Overextension/twisted Struck by an object Collision w/ object
 Physical altercation Tripped/slipped Hit w/ thrown object Collision w/ person
 Drug, alcohol, or other substance involved Contact w/ hot or toxic substance
 Other: (Describe) _____

Nature of Injury:

- Head Trunk (body) Neck Abdomen Chest Groin
 Back Skin Hand(s) Shoulder(s) Eye(s) Arm(s)
 Wrist(s) Finger(s) Hip(s) Ankle(s) Foot/Feet Toe(s)
 Other: (Describe) _____

Medical Treatment:

- No Treatment First Aid Called 911 Taken to health care center
 Hospitalized Diagnosis: _____ # days missed work: _____

Employee Signature: _____ Date & Time: _____

Supervisor Signature: _____ Date & Time: _____

Nurse's Accident Investigation Form

Name of Injured Staff: _____

What part of the body was injured? _____

Employee symptoms/injury following incident. Describe in detail. _____

What caused the event/injury? _____

Care Provided to the staff member by the School Nurse. _____

Employee went to the doctor/hospital? Doctor name _____

Hospital name _____

Follow-up treatment required? _____

Workers' Compensation Filed? Yes No

Nurse Signature: _____ Date & Time: _____