

The information collected below will be used for the purposes of attaining particulars about the accident for risk management & for use by the Division's insurance carrier. Information collected will be protected & used in compliance with the FOIPP Act.

Date and Time of Reporting this Accident: _____

Name of Injured Person: _____ Gender: M ___ F ___

School/Site: _____ Age: _____ Grade: _____

Date and Time of Accident: _____
YYYY / MM / DD TIME

INDICATE THE ONE (OR MORE) MOST APPROPRIATE STATEMENT(S) FROM EACH OF THE FOLLOWING SECTIONS (WITH AN X):

1. BODY REGION(S) INJURED:

- | | | | | |
|-------------------------------|------------------------------------|----------------------------------|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> Teeth | <input type="checkbox"/> Foreman | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Knee |
| <input type="checkbox"/> Face | <input type="checkbox"/> Neck | <input type="checkbox"/> Wrist | <input type="checkbox"/> Back | <input type="checkbox"/> Lower Leg |
| <input type="checkbox"/> Nose | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Hand | <input type="checkbox"/> Buttocks | <input type="checkbox"/> Ankle |
| <input type="checkbox"/> Eye | <input type="checkbox"/> Upper Arm | <input type="checkbox"/> Finger | <input type="checkbox"/> Groin | <input type="checkbox"/> Foot |
| <input type="checkbox"/> Ear | <input type="checkbox"/> Elbow | <input type="checkbox"/> Chest | <input type="checkbox"/> Thigh | <input type="checkbox"/> Other: _____ |

2. TYPE OF INJURY:

- Abrasion / Scrape
- Burn
- Bone Bruise – swelling and / or discoloration of bony area
- Concussion – temporary loss of orientation or unconsciousness
- Dislocation / separation – deformity of a joint
- Fracture
- Laceration / incision / puncture – an open wound
- Muscle strain (pull or tear) – due to use rather than blow
- Nose bleed
- Sprain – twisting or moving of a joint beyond normal range
- Teeth – loosened or broken
- Other: _____

3. FACILITY OR AREA IN WHICH INJURY TOOK PLACE:

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Classroom / Lab | <input type="checkbox"/> Locker Room / Shower | <input type="checkbox"/> Rink |
| <input type="checkbox"/> Gymnasium | <input type="checkbox"/> Playground – climbing / play apparatus | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Hallway / Stairway | <input type="checkbox"/> Playing Field | _____ |
| <input type="checkbox"/> In Transit to or from school | <input type="checkbox"/> Pool | _____ |

4. PROBABLE DIRECT CAUSE OF INJURY:

- Accidental collision between participants
- Blow delivered by an object (ball, bat, etc.)
- Body contact (not considered a collision) in the normal course of an activity
- Carelessness on part of pupil
- Fall / trip not due to an observed external factor
- Fall or loss of balance where apparatus concerned
- No clear or apparent cause
- Obstruction on playing area (object or spectator)
- Strain or overexertion
- Other: _____

5. SCHOOL ACTIVITY AT THE TIME OF INJURY:

- | | |
|--|---|
| <input type="checkbox"/> Before / after school, noon hour play | <input type="checkbox"/> Physical Education Instruction |
| <input type="checkbox"/> Classroom / Lab Instruction | <input type="checkbox"/> Recess |
| <input type="checkbox"/> Field trip / Out-of-school | <input type="checkbox"/> School team game / practice |
| <input type="checkbox"/> Intramural / House League | <input type="checkbox"/> Other: _____ |

6. SPECIFIC ACTIVITY:

- | | |
|---|---|
| <input type="checkbox"/> Aquatics | <input type="checkbox"/> Ice Hockey |
| <input type="checkbox"/> Basketball | <input type="checkbox"/> Ice Sports (other) _____ |
| <input type="checkbox"/> Dance | <input type="checkbox"/> Organized activity |
| <input type="checkbox"/> Field Hockey / Handball | <input type="checkbox"/> Racquet games |
| <input type="checkbox"/> Floor Hockey | <input type="checkbox"/> Soccer |
| <input type="checkbox"/> Football (tackle) | <input type="checkbox"/> Softball or Baseball |
| <input type="checkbox"/> Football (flag, touch) | <input type="checkbox"/> Track & Field/Cross Country |
| <input type="checkbox"/> Free Play | <input type="checkbox"/> Volleyball |
| <input type="checkbox"/> Games lesson | <input type="checkbox"/> Wrestling & Personal Defense |
| <input type="checkbox"/> Gymnastics (using apparatus) | <input type="checkbox"/> Miscellaneous (Please Specify) _____ |
| <input type="checkbox"/> Gymnastics (free exercise, tumbling) | _____ |

7. BRIEF DESCRIPTION OF ACCIDENT (Attach additional page if insufficient space)

8. WHAT WAS DONE FOR THE INJURED PERSON?

(Who attended to the injured person, who was contacted, where sent, and how)

Was parent/family member notified Yes / No Time: _____ Date: _____

Was the injured person transported to hospital / medicentre? Yes / No by car? By ambulance?

Witness(es) _____ Signature _____ Signature _____
to Accident:

Name (please print) Phone Number Name (please print) Phone Number

Witness(es) report attached Yes No

Principal: _____ Teacher / Staff Member in Attendance: _____
Signature Signature