GANANDA CENTRAL SCHOOL DISTRICT
INCIDENT REPORT FORM

This report is to be completed for each student in an accident/incident/injury on or off school premises while on a school sponsored event. Please complete all entries and use back if necessary. Keep a copy in the school health office. Send a copy to the Business Office.

NAME: GENDER: DOB:

SCHOOL: TEACHER/HR: GRADE: ☐ N/A

DATE OF INCIDENT: **TIME:**

LOCATION

SCHOOL: ☐ Auditorium ☐ Grounds ☐ Locker Room ☐ Restroom ☐ OTHER:
☐ Café ☐ Gymnasium ☐ Playground ☐ Stairs
☐ Classroom ☐ Hallway ☐ Pool

NON-SCHOOL: ☐ To & From ☐ Bicycle ☐ Traffic ☐ Bus

ATHLETICS/ACTIVITY

☐ Sport: ☐ Extracurricular:
☐ School Sponsored ☐ School Supervised

SYMPTOMS OBSERVED

☐ Abrasion ☐ Cut ☐ Puncture ☐ Swelling
☐ Bruise ☐ Dental ☐ Rash/Blister ☐ Other:
☐ Bump ☐ Musculoskeletal

PART OF BODY INJURED *indicate L or R next to selection*

☐ Abdomen ☐ Chest ☐ Face ☐ Head ☐ Nose ☐ Wrist
☐ Ankle ☐ Ear ☐ Finger ☐ Knee ☐ Scalp ☐ Other:
☐ Arm ☐ Elbow ☐ Foot ☐ Leg ☐ Shoulder
☐ Back ☐ Eye ☐ Hand ☐ Mouth ☐ Tooth

DESCRIPTION/NATURE *Describe how the incident occurred and the activity the person was doing:*

SUPERVISOR ON DUTY

Name: Title: Phone:

FIRST AID & FOLLOW-UP CARE PROVIDED

By Whom:
☐ Area rinsed/washed ☐ Bandaged ☐ Ice applied ☐ Rested/Observed
☐ Medication Administered Type: Time given:
☐ Other treatment:

COMMUNICATION/NOTIFICATION TO PARENT/GUARDIAN

Parent/Guardian Address: Phone:

Parent/Guardian Notified: ☐ Yes ☐ No Date: Time:
Notified via: ☐ Phone ☐ Message left ☐ Email ☐ In-person ☐ Note sent

DISPOSAL OF CASE - STUDENT WENT:

☐ Home ☐ To Class ☐ To Hospital ☐ To Physician

APPLICABLE IN THE STATE OF NEW YORK

FOR YOUR PROTECTION NEW YORK LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

Date of Report School Personnel in Charge Phone #

CONCUSSION CHECKLIST
NYSPHSAA/NYSAAA

Name: ____________________ Age: ____________ Grade: ______ Sport: ____________

Date of Injury: ____________________ Time of Injury: ________________________

On Site Evaluation

Description of Injury: ____

____

____

Has the athlete ever had a concussion?	Yes	No	
Was there a loss of consciousness?	Yes	No	Unclear
Does he/she remember the injury?	Yes	No	Unclear
Does he/she have confusion after the injury?	Yes	No	Unclear

Symptoms observed at time of injury: *circle yes or no for each*

Dizziness	Yes	No	Headache	Yes	No
Ringing in Ears	Yes	No	Nausea/Vomiting	Yes	No
Drowsy/Sleepy	Yes	No	Fatigue/Low Energy	Yes	No
"Don't feel right"	Yes	No	Feeling "Dazed"	Yes	No
Seizure	Yes	No	Poor Balance/Coord.	Yes	No
Memory Problems	Yes	No	Loss of Orientation	Yes	No
Blurred Vision	Yes	No	Sensetivity to Light	Yes	No
Vacant Stare	Yes	No	Sensitivity to Noise	Yes	No
Glassy Eyed	Yes	No			

Other Findings/Comments: ____

____

____

Final Action Taken: Parents Notified Sent to Hospital

Evaluator's Signature: ________________________ Title: ____________________

Address: ________________________ Date: ____________ Phone#: ______________