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DR. KANDACE BETHEA
Superintendent

INCIDENT REPORT

Name: _____ DOB: _____

School: _____ Grade: _____

Date of Occurrence: _____ Time: _____

First Responder: _____ Title: _____

Place of Occurrence: _____

Nature of Occurrence:

1. Respiratory
2. Emergency
3. Head Injury
4. Back Injury
5. Eye Injury
6. Fracture
7. Sprain/Strain
8. Laceration
9. Dental Injury
10. Anaphylaxis
11. Psychiatric Emergency
12. Heat Related Injury
13. Other

Body Part Affected: _____

Describe the incident:

_____

_____

_____

_____

_____

_____

Describe Treatment Disposition:

_____

_____

_____

_____

_____

Was blood or body fluids present? Yes or No

Was Responder exposed to blood or body fluids? Yes or No

Was this an exposure incident? Yes or No

Were parents notified? Yes or No

Name of parent notified: _____

Was immediate care required by physician or dentist? Yes or No

Did child lose ½ or more days of school? Yes or No

Signature of First Aid Provider: _____