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**CONFIDENTIAL SCHOOL INCIDENT INVESTIGATION**

DISTRICT NAME		SCHOOL / SITE NAME			
NAME STUDENT/PERSON (Last, First,) Student ___ Non-Student ___		HOME ADDRESS (NUMBER, STREET, APT., CITY, STATE, ZIP)			
HOME PHONE NUMBER ( )		Male: ___ Female: ___	DATE OF BIRTH	AGE	SOCIAL SECURITY #
DATE OF INCIDENT	TIME OF INCIDENT	DATE/TIME REPORTED		REPORTED TO WHOM?	
EXACT LOCATION OF INCIDENT					
DID INCIDENT INVOLVE OTHER STUDENT(S) OR NON-STUDENT(S)? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE NAME(S):					
DESCRIBE HOW THE INCIDENT OCCURRED IN DETAIL (ATTACH ADDITIONAL SHEET OR REPORT IF NECESSARY)					
WAS EQUIPMENT OR MACHINERY INVOLVED? (Playground, Industrial Arts, etc.) ___ Yes ___ No If "Yes" NOTE ANY DEFICIENCIES					
WAS A RULE OR PROCEDURE VIOLATED? EXPLAIN (Include horseplay)					
FULL NAME OF TEACHER, TEACHER'S AIDE, ETC., FOR INJURED STUDENT		TITLE OF PERSON (TEACHER, AIDE, ETC.)		PRESENT AT TIME OF INCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
NAME OF WITNESS	ADDRESS	PHONE ( )	STATUS: <input type="checkbox"/> TEACHER <input type="checkbox"/> PARENT <input type="checkbox"/> STUDENT STATEMENT ATTACHED: <input type="checkbox"/> Yes <input type="checkbox"/> No		
NAME OF WITNESS	ADDRESS	PHONE ( )	STATUS: <input type="checkbox"/> TEACHER <input type="checkbox"/> PARENT <input type="checkbox"/> STUDENT STATEMENT ATTACHED: <input type="checkbox"/> Yes <input type="checkbox"/> No		
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NATURE OF INJURY: <input type="checkbox"/> Abrasion <input type="checkbox"/> Fracture <input type="checkbox"/> Strain/Sprain <input type="checkbox"/> Concussion <input type="checkbox"/> Contusion <input type="checkbox"/> Cut <input type="checkbox"/> Dislocation <input type="checkbox"/> Internal <input type="checkbox"/> Other: <b>(Explain)</b>		INJURED PART OF BODY: <input type="checkbox"/> Left Side <input type="checkbox"/> Right Side <input type="checkbox"/> Head <input type="checkbox"/> Finger <input type="checkbox"/> Arm <input type="checkbox"/> Abdomen <input type="checkbox"/> Back <input type="checkbox"/> Chest <input type="checkbox"/> Face <input type="checkbox"/> Neck <input type="checkbox"/> Eye <input type="checkbox"/> Leg <input type="checkbox"/> Hand <input type="checkbox"/> Foot <input type="checkbox"/> Other <b>(Explain)</b>			
FIRST AID TREATMENT GIVEN		NAME OF PERSON WHO ADMINISTERED FIRST AID			
PARENT/GUARDIAN NAME		DATE & TIME CONTACTED	DISPOSITION: <input type="checkbox"/> RETURN TO CLASS <input type="checkbox"/> HOME <input type="checkbox"/> DOCTOR <input type="checkbox"/> 911/HOSPITAL <input type="checkbox"/> OTHER: _____ TRANSPORTED BY: _____		
PARENT ATTITUDE OR OTHER COMMENTS					
NAME OF PERSON COMPLETING REPORT		TITLE	PHONE NUMBER	DATE PREPARED	
SIGNATURE / SITE ADMINISTRATOR			<b>CONFIDENTIAL ATTORNEY/CLIENT PRIVILEGE</b>		

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