OHIO DEPARTMENT OF HEALTH
STUDENT INJURY REPORT FORM

Student Information

Name _____ Date of Incident _____

Date of Birth _____ Time of Incident _____

Grade _____ Male _____ Female _____

Parent/Guardian Information

Name(s) _____

Address/City/State/Zip _____

Phone# Work _____ Home _____

School Information

School _____ Phone# _____

Principal _____

District _____ Phone# _____

Location of Incident (check appropriate line):

____Athletic Field
____Cafeteria
____Classroom
____Gymnasium
____Hallway
____Bus
____Stairway
____Restroom
____Playground
____No equipment involved
____**Equipment involved** (please describe)
_____
____Parking Lot
____Vocation/Shop lab
____Other (please explain): _____

When Did the Incident Occur (check appropriate line):

____Recess
____Lunch
____P.E. Class
____In Class (not P.E.)
____Class Change
____Athletic Practice/Session
____Athletic Team Competition
____Intramural Competition
____Before School
____After School
____Field Trip
____Unknown
____Other _____

Surface (check all that apply):

____Asphalt
____Carpet
____Concrete
____Dirt
____Gravel
____Ice/snow
____Lawn/Grass
____Mat(s)
____Sand
____Wood chips/mulch
____Tile
____Synthetic Surface
____Gymnasium Floor
____Other (specify) _____

	Head	Eye	Ear	Nose	Mouth/Lips	Tooth/Teeth	Jaw	Chin	Neck/Throat	Collarbone	Shoulder	Upper Arm	Elbow	Forearm	Wrist	Hand	Finger	Fingernail	Chest/Ribs	Back	Abdomen	Groin	Genitals	Pelvis/Hip	Leg	Knee	Ankle	Foot	Toe
Abrasion/Scrape																													
Bite																													
Bump/Swelling																													
Bruise																													
Burn/Scald																													
Cut/Laceration																													
Dislocation																													
Fracture																													
Pain/Tenderness																													
Puncture																													
Sprain																													
Other																													

Contributing Factors (check all that apply):

____Animal bite
____Collision with object
____Collision with person
____Compression/pinch
____Fall
____Fighting
____Overextension/twisted
____Foreign body/object
____Hit with thrown object
____Tripped/slipped
____Struck by object (bat, swing, etc.)
____Struck by auto, bike, etc.
____Contact with hot or toxic substance
____Drug, alcohol or other substance involved
____Weapon
Specify _____
____Unknown
____Other _____

Description of Incident: _____

_____

_____

_____

Witnesses to the Incident: _____

_____

Staff Involved: ____Teacher ____Nurse ____Principal ____Assistant staff ____Custodian ____Bus driver
____Secretary ____Cafeteria ____Other (specify) _____

Incident Response (check all that apply):

____First aid
Time _____ By whom _____
____Parent/guardian notified
Time _____ By whom _____
____Unable to contact parent/guardian
Time _____ By whom _____
____Parents deemed no medical action necessary
____Returned to class
____Sent/taken home
Days of school missed _____
____Assessment/follow-up by School Nurse
Action taken _____
____Called 911
____Taken to health care provider/clinic/hospital/urgent care
Diagnosis _____
Days of school missed _____
____Hospitalized
Diagnosis _____
Days of school missed _____
____Restricted school activity
Please explain _____
Length of time restricted _____
Days of school missed _____
____Other _____

Describe care provided to the student: _____

_____

_____

Additional comments: _____

_____

_____

_____

Signature of staff member completing form _____ Date/time _____
Nurse's signature _____ Date/time _____
Principal's signature _____ Date/time _____