BWC Policy Number 33705151-0

CompManagement Health Systems (MCO)
Fax No: 1-800-334-4229

LOGAN HOCKING SCHOOLS
INCIDENT REPORT

Procedure: This form is to be completed for all incidents occurring on school property, or during any school activity that requires medical or dental attention to be administered. This report is to be completed as soon after incident as possible by school personnel supervising an activity, a nurse, supervisor, or other appropriate individual.

A. General Information. This section to be completed for all incidents.

Personal Information Student – Employee – Visitor

Incident Information

_____ _____
Name of Injured Date of Birth

_____ _____
Date of Incident Time of Incident

_____
Social Security Number

_____ _____
Address If Employee: Normal Work Hours

_____ _____ _____ _____
Telephone No. (single or married) # of Dependents Location (building/department)

B. This section to be completed for **student** incidents only.

STUDENT INCIDENT SEND COPIES TO: SAFETY COORDINATOR (ORIGINAL), BUILDING PRINCIPAL (1), STUDENT HEALTH RECORD (1)

School _____ Grade _____ Parents Notified? Yes No

Supervised Activity? Yes No Person in charge: _____

Accident Location: Classroom Playground Gym Bus Other (Specify)_____

C. Type of Injury. This section to be completed for **all incidents**.

Abrasion Concussion Strain/Sprain Fracture Bruise Cut

Laceration Puncture Burn Dislocation Other (Specify)_____

D. Part of body involved. This section to be completed for **all incidents**. (Patient right or left)

left		right	left		right	left		right	left		right
	Chest			Neck			Shoulder			Hip	
	Back			Teeth			Upper Arm			Upper Leg	
	Abdomen			Face			Lower Arm			Lower Leg	
	Groin			Eye			Elbow			Knee	
	Ear			Nose			Scalp			Toes	
	Fingers			Ankle			Mouth			Hand	

E. Cause of Incident. This section to be completed for **all incidents**.

Animal/Insect Bite Collision with person Toxic substance Fighting Struck by vehicle Struck by object

Collision with object Lifting Exposure to weather Exposure to Blood Hot surface/substance Slip/trip/fall

Other (specify)_____

Over

INCIDENT REPORT – continued

F. Written Narrative. This section to be completed for **all incidents**.

Describe incident, giving full details _____

_____

_____

_____

G. First aid given. This section to be completed for **all incidents**.

First Aid administered: _____

_____

Aid administered by: _____

H. Further Care. This section to be completed for **all incidents**.

☐ None

☐ Transported by ambulance to _____

☐ Other (Specify)_____

☐ Parent/relative took home

☐ Saw personal physician/dentist

J. Additional Remarks. This section to be completed for **all incidents**.

_____

_____

_____

Signature of Person Completing This Form

J. This section to be completed for **employee incidents** (for office use only).

Employee Title:_____ Return to work date: _____

Employee Date of Hire:_____

Did incident occur during normal course of work?	☐ Yes	☐ No
Is incident OSHA reportable?	☐ Yes	☐ No
Was incident logged on OSHA Form 200?	☐ Yes	☐ No
Was CompManagement Health Systems called? 1-888-247-7799	☐ Yes	☐ No

All Non Student Incidents:
Send copies to: Safety Coordinator (original), Assistant Superintendent (1)
building principal/manager/supervisor (1), Treasurer's office (1), Staff member (1)