

HALL COUNTY SCHOOL SYSTEM
STUDENT ACCIDENT REPORT
Please complete all Sections



To be completed by School Staff/Witness

School: _____ Accident Date: _____ Time: _____ a.m. ___ p.m. ___

Student Name: _____ DOB: _____ Home Telephone #: _____

Home Address: _____ City: _____

Did school staff witness accident? Yes _____ No _____

Type of Injury: _____ Part of body affected: _____

School staff witness/description of accident and location: _____

Name of supervising staff when accident occurred: _____

Action taken: Sent to clinic: _____ accompanied by: _____

Sent to office: _____ accompanied by: _____ Nurse called to scene: _____

Adult witness/School Staff signature: _____ Date: _____

To be completed by School Nurse, if seen in Clinic

If seen by school nurse, please describe nature of injury: _____

Actions taken by school nurse: _____

School nurse signature: _____ Date: _____

To be completed by School Staff, Nurse or Office Staff

Parent/Guardian notified: Yes: _____ No: _____ Time: _____ a.m. ___ p.m. ___

By whom: _____

Student Released: Back to class _____ To parent/guardian _____ 911 called _____

Sent to hospital by ambulance ___ by: personal vehicle/name: _____ Time: _____

Principal Signature: _____ Date: _____ Date Received: _____

Superintendent's office notified: Yes: _____ No: _____

Please forward ASAP a copy to the Central Office/Andrea Williamson-English, Health Services Coordinator.

*If additional information becomes available at a later time, notify Andrea Williamson-English by email.

Updated: 3/25/2021