Huron Intermediate School District Policy # 00533-201010
STUDENT/VISITOR INJURY REPORT – FORM 2C

Injured Person's Name: ______________________________ ☐ Male ☐ Female

Address: ______________________________ Phone #: ______________

City/State/Zip: ______________________________ Birth Date: ______________

Injured is a: ☐ visitor ☐ student If visitor, state purpose of visit: ______________________________
If student, parent name: ______________________________

Date of injury: ______________________ Time: __________ ☐ a.m. ☐ p.m.

Occurred at: ☐ Huron Technical Center ☐ Huron Learning Center ☐ HISD Admin. ☐ Transition building
☐ PREP building ☐ Storage shed ☐ Other ______________

Nature of injury:		*Place of injury:*		*Body part injured:*		
☐ Scratch	☐ Head injury	☐ Classroom	☐ Gymnasium	☐ Left	☐ Right	
☐ Fracture	☐ Sprain/strain	☐ Hallway	☐ Parking lot	☐ Ankle	☐ Foot	☐ Leg
☐ Bruise	☐ Cut/puncture	☐ Bathroom	☐ Sidewalk	☐ Arm	☐ Face	☐ Nose
☐ Burn	☐ Bite	☐ Cafeteria	☐ Playground	☐ Back	☐ Finger	☐ Teeth
☐ Dislocation	☐ *Blood exposure	☐ Athletic field	☐ Office	☐ Neck	☐ Hand	☐ Wrist
☐ Other __________		☐ Other __________		☐ Eye	☐ Knee	☐ Shoulder
				☐ Head	☐ Other __________	

*If blood exposure, complete exposure worksheet

How did the injury occur? (List basic facts chronologically. Give factual detail. Use back of form if needed.)

Describe any conditions that appeared to contribute to the injury or exposure (i.e. wet floor, horseplay, etc.):

What safety devices were/were not in use?

List names of witnesses:
Name______________________ Phone__________ Name______________________ Phone__________

Injured person was: ☐ sent back to program ☐ sent home ☐ sent to physician ☐ sent to hospital

Medical treatment:
☐ No medical treatment needed ☐ First Aid given; advised to seek further medical treatment
☐ Medical treatment declined ☐ First Aid given; transported to ER via school vehicle
☐ First Aid given ☐ First Aid given; ambulance service called

Describe first aid given:

Information for this form obtained from: ☐ Injured person ☐ Witnesses

______________________________ ______________________ ______________
Report prepared by: Title Date

Office Use Only: Claim #:______________________ Date entered:______________________

Revised 2/2011