Taylor County School District
Visitor/ Guest Accident/Incident Report

PERSONAL INFORMATION

Name:_____Date of Birth:_____☐ Male _☐ Female

Permanent Address:_____Phone: (___)_____

City:_____State:_____Zip Code:_____

DETAIL OF INJURY/ACCIDENT

Date of Injury/Accident:_____Time of Injury/Accident:_____ ☐ AM ☐ PM

Activity Engaged in at Time of Injury/Accident:_____

Body Part Injured: ☐ Right ☐ Left

☐ Head	☐ Lip	☐ Shoulder	☐ Hand	☐ Thigh
☐ Forehead	☐ Nose	☐ Upper Back	☐ Fingers	☐ Knee
☐ Eye	☐ Throat	☐ Lower Back	☐ Chest	☐ Lower Leg
☐ Eyebrow	☐ Ear	☐ Upper Arm	☐ Stomach	☐ Ankle
☐ Mouth	☐ Neck	☐ Lower Arm	☐ Ribs	☐ Foot
☐ Jaw	☐ Collar Bone	☐ Wrist	☐ Buttocks	☐ Toe

Did injury require medical treatment? ☐Yes ☐ No If yes, please provide:

Name & Location of Facility:_____

Name of Treating Physician:_____

Was the injured person transported by ambulance for treatment? ☐ Yes ☐ No

Was law enforcement personnel contacted? ☐ Yes ☐ No

Specific Description of How the Accident/Injury Occurred: _____

_____

_____

_____

_____

Was Personal Property Damaged? ☐ Yes ☐ No If yes, provide a description of the property.

_____

_____

WITNESS INFORMATION

Were there witnesses to the accident/incident? ☐ Yes ☐ No

Witness # 1

Name:_____Phone or Contact Information:_____

Statement:_____

_____

Witness # 2

Name:_____Phone or Contact Information_____

Statement:_____

_____

SIGNATURE

I verify this information is complete and accurate to the best of my knowledge.

_____ _____

Printed Name of Person Completing Form Date

*****Please attach photos and send electronic file to the district office. All information on this form is CONFIDENTIAL, and should not be released to the public.***

Return Completed Form to the Benefits Office
318 North Clark Street
Perry, Fl 32347
Phone: 850-838-2500
Fax: 850-838-2501