RED BLUFF JOINT UNION HIGH SCHOOL DISTRICT
STUDENT ACCIDENT REPORT

(Subject to Attorney-Client Privilege, Prepared for Litigation Purposes) ***Confidential***

Complete and submit this form within 24 hours.
In case of serious injury, report to District Office by telephone immediately.

Student ID# _____

Name of injured: _____ Sex: _____ Age: _____ Grade: _____

Address: _____

School: _____ Date of Accident: _____ Time of Accident: _____

CHECK APPROPRIATE BOXES

- ☐ Athletic Field
- ☐ Bathroom
- ☐ Cafeteria
- ☐ Classroom
- ☐ Ceramics
- ☐ Corridor
- ☐ Field House
- ☐ Grounds
- ☐ Gym
- ☐ Locker Room
- ☐ Mat Room
- ☐ PAC
- ☐ Pool
- ☐ Stairs
- ☐ Shower
- ☐ Shop Lab
- ☐ Science Lab
- ☐ Weight Room

CHECK APPROPRIATE BOXES

- ☐ No Visible Injury
- ☐ Abrasion
- ☐ Bite
- ☐ Bruise
- ☐ Burn
- ☐ Cut
- ☐ Deformity
- ☐ Puncture
- ☐ Redness
- ☐ Swelling
- ☐ Tooth Chipped
- ☐ Tooth Loose
- ☐ Tooth Lost

CHECK APPROPRIATE BOXES

- ☐ Abdomen
- ☐ Ankle
- ☐ Arm
- ☐ Back
- ☐ Chest
- ☐ Chin
- ☐ Ear
- ☐ Eye
- ☐ Finger
- ☐ Foot
- ☐ Hand
- ☐ Head
- ☐ Hip
- ☐ Knee
- ☐ Leg
- ☐ Lip
- ☐ Mouth
- ☐ Neck
- ☐ Nose
- ☐ Shoulder
- ☐ Tooth
- ☐ Wrist

Other (Specify): _____

Other (Specify): _____

Other (Specify): _____

How did the accident happen? What was the student doing? Where was the student? List any unsafe acts and unsafe conditions present. Specify any tool, machine or equipment involved.

Teacher in charge when accident occurred: _____ Present at scene of accident: ☐ Yes ☐ No

First Aid Treatment _____ By Name: _____

Sent Home _____ By Name: _____

Sent to Hospital _____ By Name: _____

Name of Hospital: _____

Sent to School Nurse _____ By Name: _____

Sent to Physician _____ By Name: _____

Physician's Name: _____

Was parent or other individual notified? ☐ Yes ☐ No When: _____ How: _____

Name of individual notified _____

Witness: Name _____ Address: _____

Name _____ Address: _____

Signed _____ Administrator _____ Date _____