



**STUDENT INJURY ACCIDENT REPORT
INSTRUCTIONS**

- At beginning of every fiscal year, discard current copies on file and download updated form
- Must be completed if injury requires or it is advised to seek professional medical attention away from location
- Completed **ONLY** by school or parish representative
 - Coaches should have copy on-hand at all games to complete at time of injury
- Submit within 48 hours of injury, preferably scanned and emailed
 - DO NOT wait until medical treatment/diagnosis is confirmed
- **INTERNAL DOCUMENT ONLY**
 - Parent/Guardian are not to be given a copy as this is for reporting only
 - If parent/guardian asks, you may notify them it has been reported to the Diocese Office of Risk Management and Risk Management may contact you via email with information regarding the process for filing a claim
- Complete ALL information on form to include
 - Student DOB
 - Parent email
 - Date of accident/injury
 - Location where accident/injury occurred
- If not completing on-line fillable form, please PRINT LEGIBLY
- Ensure all information is accurate and correct including spelling of student name, parent email address
 - This information is used when contacting the parent
- The form is used to report accidents and not medical emergencies due to existing conditions or allergic reactions caused by the student



STUDENT INJURY ACCIDENT REPORT

TO BE COMPLETED BY SCHOOL/PARISH REPRESENTATIVE
SUBMIT WITHIN 48 HOURS OF INJURY

COMPLETE IF INJURY REQUIRES ANY PROFESSIONAL MEDICAL TREATMENT.
INCOMPLETE FORMS WILL NOT BE PROCESSED.

****PLEASE PRINT LEGIBLY****

Name of School/Parish/CYO: _____

Name of Injured Student: _____
LAST NAME FIRST NAME

Gender: [] M [] F DOB (mm/dd/yyyy): ____/____/____

Student's Complete Mailing Address: _____
CITY STATE ZIP

Parent Email: _____

Date of Accident (mm/dd/yyyy): ____/____/____ Time: _____

If athlete, date first seen by athletic trainer (mm/dd/yyyy): ____/____/____

Date and Time Parent Notified by the location (mm/dd/yyyy): ____/____/____ Time: _____

Location Where Injury Occurred (e.g., gym, field, playground, etc.): _____

If athlete, what sport (e.g., basketball, football, etc.): _____

Detailed Description of Accident: Please use separate sheet if more space is needed.

Description of Aid Given

Staff Person Giving Aid: _____

Location of Injury (e.g., right arm, left leg, etc.): _____

Initial Assessment of Injury (e.g., sprain, break, laceration, etc.): _____

Determined by (e.g., nurse, athletic trainer, etc.): _____

Did injury require or was student advised to seek professional medical attention away from School?

[] Yes [] No [] Advised [] Unknown

Future plans to prevent recurrence: _____

Name of Person Completing Report: _____ Phone Number: _____

Title/Position of Person Completing Report: _____ Date: ____/____/____

Signature of Person Completing Report _____

SUBMIT TO RISK MANAGEMENT WITHIN 48 HOURS OF INJURY

riskmanagement@arlingtondiocese.org