Office of Risk Management
Catholic Diocese of Arlington
Phone: 703-841-2503
Fax: 703-841-4786

STUDENT INJURY ACCIDENT REPORT

THIS FORM MUST BE COMPLETED WITHIN 72 HOURS OF THE INJURY. THIS FORM MUST BE FILLED OUT IF INJURY REQUIRES EMERGENCY ROOM, HOSPITAL, DOCTOR OR OUTSIDE CLINIC ATTENTION. INCOMPLETE FORMS WILL NOT BE PROCESSED.

*******PLEASE PRINT*******

Name of School _____

Name of Injured Student_____ Sex (M/F) **DOB**_____

Student's **Complete** Mailing Address_____
_____

Date of Accident _____ Time: _____
Location of Accident (e.g., gym, field, playground)_____

Detailed Description of Accident (use back for additional space) _____
_____
_____
_____

Description of Aid Given
_____
_____

Staff Person Giving Aid _____
Did injury require medical treatment away from School (Y/N/Unk)_____

Nature and Type of Injury _____
Determined by (e.g., nurse, doctor, urgent care)_____

Date and Time Parent Notified _____

Parent Email (if known)_____

Future plans to prevent recurrence _____
_____

Name of Person Completing Report _____ Contact # _____

Signature & Title of Person Completing Report _____

Signature of Principal or Supervisor _____ Date _____