



### Detroit Public Schools Student Accident Report

**Part A.**

### Report ALL accidents to Students Occurring Anywhere, Day or Night

1. Name: _____	Home Address: _____																						
2. School: _____	Sex: M <input type="checkbox"/> ; F <input type="checkbox"/> Age: _____ Grade or classification _____																						
3. Time accident occurred: Hour _____ A.M. _____ P.M. Date: _____																							
4. Place of Accident: School Bldg <input type="checkbox"/> School Grounds <input type="checkbox"/> To or from School <input type="checkbox"/> Home <input type="checkbox"/> Field Trip <input type="checkbox"/> Bus <input type="checkbox"/>																							
<b>NATURE OF INJURY</b>	<table style="width: 100%; border: none;"> <tr> <td style="padding: 2px;"><input type="checkbox"/> Abrasion</td> <td style="padding: 2px;"><input type="checkbox"/> Fracture</td> </tr> <tr> <td style="padding: 2px;"><input type="checkbox"/> Amputation</td> <td style="padding: 2px;"><input type="checkbox"/> Laceration</td> </tr> <tr> <td style="padding: 2px;"><input type="checkbox"/> Asphyxiation</td> <td style="padding: 2px;"><input type="checkbox"/> Poisoning</td> </tr> <tr> <td style="padding: 2px;"><input type="checkbox"/> Bite</td> <td style="padding: 2px;"><input type="checkbox"/> Puncture</td> </tr> <tr> <td style="padding: 2px;"><input type="checkbox"/> Bruise</td> <td style="padding: 2px;"><input type="checkbox"/> Scalds</td> </tr> <tr> <td style="padding: 2px;"><input type="checkbox"/> Burn</td> <td style="padding: 2px;"><input type="checkbox"/> Scratches</td> </tr> <tr> <td style="padding: 2px;"><input type="checkbox"/> Concussion</td> <td style="padding: 2px;"><input type="checkbox"/> Shock (el.)</td> </tr> <tr> <td style="padding: 2px;"><input type="checkbox"/> Cut</td> <td style="padding: 2px;"><input type="checkbox"/> Sprain</td> </tr> <tr> <td style="padding: 2px;"><input type="checkbox"/> Dislocation</td> <td></td> </tr> <tr> <td colspan="2" style="padding: 2px;"><input type="checkbox"/> Other (specify) _____</td> </tr> </table>	<input type="checkbox"/> Abrasion	<input type="checkbox"/> Fracture	<input type="checkbox"/> Amputation	<input type="checkbox"/> Laceration	<input type="checkbox"/> Asphyxiation	<input type="checkbox"/> Poisoning	<input type="checkbox"/> Bite	<input type="checkbox"/> Puncture	<input type="checkbox"/> Bruise	<input type="checkbox"/> Scalds	<input type="checkbox"/> Burn	<input type="checkbox"/> Scratches	<input type="checkbox"/> Concussion	<input type="checkbox"/> Shock (el.)	<input type="checkbox"/> Cut	<input type="checkbox"/> Sprain	<input type="checkbox"/> Dislocation		<input type="checkbox"/> Other (specify) _____			
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<b>DESCRIPTION OF THE ACCIDENT</b> How did accident happen? What was student doing? Where was student? Specify any tool, machine or equipment involved. _____ _____ _____ _____ _____ _____ _____																							

6. Degree of Injury:  Death  Permanent Impairment  Temporary (lost time)  Non-Disabling (no lost time)

7. Total number of days lost from school: \_\_\_\_\_ (If more than 48 hours report on Form 54 when student returns)

#### Part B. Additional Information on School Jurisdiction Accidents

8. Teacher in charge when accident occurred (Enter name): \_\_\_\_\_  
Present at scene of accident: NO  YES

9. **IMMEDIATE ACTION TAKEN**

<input type="checkbox"/> First-aid treatment	By (Name): _____
<input type="checkbox"/> Sent to school nurse	By (Name): _____
<input type="checkbox"/> Sent home	By (Name): _____
<input type="checkbox"/> Sent to physician	By (Name): _____
Physician's Name: _____	
<input type="checkbox"/> Sent to hospital	By (Name): _____
Name of hospital: _____	

10. Was a parent or other individual notified?  NO  YES When \_\_\_\_\_ How \_\_\_\_\_  
Name of individual notified: \_\_\_\_\_  
By whom? (Enter name): \_\_\_\_\_

11. Witnesses: 1. Name: \_\_\_\_\_ Address: \_\_\_\_\_  
2. Name: \_\_\_\_\_ Address: \_\_\_\_\_

12. **LOCATION**

	<b>Specify Activity</b>	
Athletic field	Locker	_____
Auditorium	Pool	_____
Cafeteria	Sch. Grounds	_____
Classroom	Stairwell	_____
Corridor	Showers	_____
Dressing room	Stairs	_____
Gymnasium	Restroom	_____
Vo-Tech Lab	Playground	_____
Laboratories	Other (specify)	_____

**Please fax your completed report to the  
Office of Risk Management at  
(313) 873-0872**

Signed Principal: \_\_\_\_\_ Teacher: \_\_\_\_\_

