Calhoun Falls Charter School
School Health Program
Injury Report

Date of Injury: _____

Time: _____

SECTION 1 – to be completed by first responder

Name: _____ DOB: _____/_____/_____

Grade: _____ Homeroom Teacher: _____

Location	Nature	Body Parts	
○ Bus	○ Respiratory Emergency	○ Abdomen	○ Foot
○ Hallway	○ Head Injury	○ Ankle	○ Hand
○ Classroom	○ Back Injury	○ Arm	○ Head
○ School Grounds	○ Eye Injury	○ Back	○ Knee
○ Athletic Field	○ Fracture/Sprain/Strain	○ Chest	○ Leg
○ Shop	○ Laceration	○ Ear	○ Mouth
○ Rest Room	○ Dental Injury	○ Elbow	○ Teeth
○ Cafeteria	○ Anaphylaxis	○ Eye	○ Wrist
○ Gymnasium	○ Psychiatric Emergency	○ Face	○ Neck
○ Other	○ Heat Related Emergency	○ Finger	○ Other
	○ Other		

Describe Incident: _____

_____

_____

Signature of person completing this section

SECTION 2 – to be completed by School Nurse or Principal's Designee

Describe Injury: _____

_____

	Yes	No	Comment
Was blood or body fluid present?			
Was the responder exposed to blood or body fluid?			
Was this an exposure incident?			
Was parent/guardian notified?			Name:
Contacted How?		By Whom?	

First Aid Treatment Provided	
By Whom?	Describe:

Disposition

O RTC O Sent Home O Sent to Health Care Provider (Name) _____
O Sent to Emergency Room/Urgent Care O Other (List) _____
Lose more than ½ day of school? _____ If so, how many? _____

_____ _____

Signature of School Nurse (or Principal's Designee) Date Signature of Principal Date