Meade School District 46-1
Student Accident Report Form

Accidents causing injury that necessitate treatment and/or are of sufficient concern must be reported.

Name: ____

DOB: ________________ Grade: ________ School: __________________________________

Date of Accident: ____________Time: _________ Where: __________________________________

Parent/Guardian:____

Phone number and address:____

Parent/Guardian Notified: Yes __ No__ By Whom:______________________________Time:___________

Type of Treatment: (please check one)

__No Treatment

__On-Site Treatment

__Emergency Medical Services Transport

__Other:____

Parent/Guardian Chose to:

__Leave student at school

__Take student home

__Take student to Medical Practitioner

__Other: ____

Staff signature filing report: ____Date:_____________

Staff printed signature filing report:____

Signature of Principal or Designee: ____Date:_____________

Copy to Business Office: Date sent:______________By whom:______________________________________

Please describe the accident and location; use the back of the page if necessary:

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