



VERNON PUBLIC SCHOOLS

STUDENT/NON-EMPLOYEE INJURY REPORTING FORM

Today's Date: _____

Date of Incident:		Time of Incident:	
Incident Address:			
Incident Reporter Name:			Phone:
Claimant Name:		DOB:	
Home Address:		Home Phone:	
City:		State:	ZIP:
If Minor, Parent Name:		Parent Phone:	
Parent address (if different from above):			
City:		State:	ZIP:
Was parent notified: <input type="checkbox"/> YES <input type="checkbox"/> NO	Time:	By Whom?	
If Student, School Name:	Teacher:	Grade:	
If student, did accident occur while student was supervised? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, include name of supervisor(s):			
Specific location at address where incident took place:			
Witness to the incident? <input type="checkbox"/> YES <input type="checkbox"/> NO	Name(s) of witness:		
(If yes, complete witness statement)			
Treated by Nurse/Employer: <input type="checkbox"/> YES <input type="checkbox"/> NO		Refused Medical Attention: <input type="checkbox"/> YES <input type="checkbox"/> NO	
Other Medical Provider: <input type="checkbox"/> YES <input type="checkbox"/> NO	Name/Address:		
Describe the bodily injury sustained including specific affected body parts (i.e. left/right, inner/outer, etc.):			

Describe how the incident occurred including events leading up to the incident (what you saw or heard):	
On-site treatment:	
Do you have a pre-existing injury to the affected area? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, describe previous injury including date.	
*Claimant's Signature:	Date:
Nurse's Signature:	Date:

ALL INJURIES SHOULD BE REPORTED WITHIN 24 HOURS OF ACCIDENT.

Please fax to Central Office at 860-870-3765 or email to: safety@vernon-ct.gov.

*NOTE: Claimant's signature is for non-employees only. Students are not required to sign this document.