



Office of Risk Management
Catholic Diocese of Arlington
Phone: 703-841-2503
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Appendix F-7

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 _____