

# Manitoba School Boards Association NON-STUDENT ACCIDENT INCIDENT REPORT

School Division: **Frontier School Division**

School: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name of Injured Person: \_\_\_\_\_ Date of Birth (M/D/Y): \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Date of Accident (M/D/Y): \_\_\_\_\_ Time of Accident: \_\_\_\_\_  A.M.  P.M.

Where did the accident occur?:

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Industrial Arts Class | <input type="checkbox"/> Laboratory        | <input type="checkbox"/> Bus                          | <input type="checkbox"/> Other (specify): |
| <input type="checkbox"/> Home Economics Class  | <input type="checkbox"/> School Playground | <input type="checkbox"/> Physical Education – Outside |   |
| <input type="checkbox"/> Classroom             | <input type="checkbox"/> Field Trip        | <input type="checkbox"/> Physical Education – Inside  |   |

Describe in detail how the accident occurred:

*\*Please ensure you include what was occurring before, during and after the incident. Please ensure you provide as much context as possible.*

- Guidelines on classification of accident/injuries:
- “MINOR”** – Scratch, Bruise, Scrape, Minor Cut, Minor Sprain, etc.
  - “MODERATE”** – Serious Cut, More Severe Sprain, Broken Finger, etc.
  - “SEVERE”** – Injury to Eye, Face, Back, Broken Arm/Leg, etc.

Nature of Injury:

- |                                |                                |                               |                                     |   |
|--------------------------------|--------------------------------|-------------------------------|-------------------------------------|---|
| <input type="checkbox"/> Cut   | <input type="checkbox"/> Crush | <input type="checkbox"/> Burn | <input type="checkbox"/> Fall       | <input type="checkbox"/> Amputation             |
| <input type="checkbox"/> Break | <input type="checkbox"/> Poke  | <input type="checkbox"/> Hit  | <input type="checkbox"/> Concussion | <input type="checkbox"/> Other (specify): _____ |

Type of Injury (body part):

- |                              |                                    |                                     |                                     |                                 |   |
|------------------------------|------------------------------------|-------------------------------------|-------------------------------------|---------------------------------|---|
| <input type="checkbox"/> Arm | <input type="checkbox"/> Head/Face | <input type="checkbox"/> Hip        | <input type="checkbox"/> Lower Back | <input type="checkbox"/> Foot   | <input type="checkbox"/> Toe              |
| <input type="checkbox"/> Leg | <input type="checkbox"/> Chest     | <input type="checkbox"/> Upper Back | <input type="checkbox"/> Hand       | <input type="checkbox"/> Finger | <input type="checkbox"/> Other (specify): |

Where on the body?:  Left  Right  Not applicable

Any additional comments?:

*\*Details from hospital, dental, x-ray information, etc.*

Was the injury treated?:  Yes  No  Unknown  Other (specify): \_\_\_\_\_

If treated, by whom?: \_\_\_\_\_ If treated, type of treatment: \_\_\_\_\_

Name of Witness(es): \_\_\_\_\_

Additional comments:

Name of School Principal or Supervisor (in full): \_\_\_\_\_

Submitted By: \_\_\_\_\_ Date of Submission (M/D/Y): \_\_\_\_\_