



Student Athlete Incident/Injury Report

Risk Management
Mat-Su Borough School District
501 N. Gulkana
Palmer, AK 99645
P (907) 746-9213 || F (907) 761-4091

Print Form

Report Date:

Special Instructions: Any adult witness, at the time of the incident, must complete this report.

Attending School Date & Time of Incident

Student Name Grade DOB Male Female

Last First MI

Parent/Guardian Phone

Incident Occurred On or In:

<input type="checkbox"/> Parking Lot	<input type="checkbox"/> Stairs	<input type="checkbox"/> Restroom	<input type="checkbox"/> Ice Rink	<input type="checkbox"/> Wrestling
<input type="checkbox"/> School Grounds	<input type="checkbox"/> Gym	<input type="checkbox"/> Hallway	<input type="checkbox"/> Shop	<input type="checkbox"/> Other: Indicate Below
<input type="checkbox"/> Classroom	<input type="checkbox"/> Chemistry Lab	<input type="checkbox"/> Bus/Bus Stop	<input type="checkbox"/> Football Field	<input type="text"/>
<input type="checkbox"/> Cafeteria	<input type="checkbox"/> Home Economics	<input type="checkbox"/> Playground	<input type="checkbox"/> Locker Room	

Incident Cause: Select one or fill in the blank if necessary.

<input type="checkbox"/> Over Exertion	<input type="checkbox"/> Improper Guarding	<input type="checkbox"/> Protrusion/Projection	<input type="checkbox"/> Exposure to Cold
<input type="checkbox"/> Hit by Object	<input type="checkbox"/> Surface Material	<input type="checkbox"/> Collision/Bumped	<input type="checkbox"/> Fainting
<input type="checkbox"/> Entrapment	<input type="checkbox"/> Horseplay	<input type="checkbox"/> Slip/Fall (Same Level)	<input type="checkbox"/> Other: Indicate Below
<input type="checkbox"/> Improper Use	<input type="checkbox"/> Mechanical Failure	<input type="checkbox"/> Slip/Fall (Different Level)	<input type="text"/>
<input type="checkbox"/> Fighting	<input type="checkbox"/> Bite	<input type="checkbox"/> Equip Congestion/Fall Zones	

Type of Injury:

<input type="checkbox"/> Abrasion	<input type="checkbox"/> Internal/Body Reaction	<input type="checkbox"/> Possible Dislocation	<input type="checkbox"/> Scratches
<input type="checkbox"/> Amputation	<input type="checkbox"/> Laceration	<input type="checkbox"/> Possible Fracture	<input type="checkbox"/> Swelling
<input type="checkbox"/> Bruise	<input type="checkbox"/> Puncture	<input type="checkbox"/> Possible Sprain	<input type="checkbox"/> Other: Indicate Below
<input type="checkbox"/> Burn	<input type="checkbox"/> Possible Concussion	<input type="checkbox"/> Possible Tear/Strain	<input type="text"/>

Part of Body Injured:

<input type="checkbox"/> Abdomen	<input type="checkbox"/> Ear	<input type="checkbox"/> Head	<input type="checkbox"/> Leg	<input type="checkbox"/> Shoulder
<input type="checkbox"/> Ankle	<input type="checkbox"/> Elbow	<input type="checkbox"/> Face	<input type="checkbox"/> Mouth	<input type="checkbox"/> Tooth
<input type="checkbox"/> Arm	<input type="checkbox"/> Eye	<input type="checkbox"/> Finger	<input type="checkbox"/> Neck	<input type="checkbox"/> Wrist
<input type="checkbox"/> Back	<input type="checkbox"/> Hip	<input type="checkbox"/> Foot	<input type="checkbox"/> Nose	<input type="checkbox"/> Other: Indicate Below
<input type="checkbox"/> Chest	<input type="checkbox"/> Hand	<input type="checkbox"/> Knee	<input type="checkbox"/> Scalp	<input type="text"/>

Incident Description:

Witness Name: Witness Job Title:

Student Referred to:

<input type="checkbox"/> Physician	<input type="checkbox"/> Home	<input type="checkbox"/> Other: Indicate Below
<input type="checkbox"/> Emergency Room	<input type="checkbox"/> Returned to Class/Play	<input type="text"/>

Student Transported by:

<input type="checkbox"/> Parent/Guardian	<input type="checkbox"/> Ambulance	<input type="checkbox"/> Self
<input type="checkbox"/> Bus	<input type="checkbox"/> Not Transported	<input type="checkbox"/> Other: Indicate <input type="text"/>

Who was Notified:

<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Other: Indicate Below
<input type="text"/>		

Notification made by:

<input type="checkbox"/> Phone	<input type="checkbox"/> Letter	<input type="checkbox"/> Email
<input type="checkbox"/> Office/Appointment	<input type="checkbox"/> Home	<input type="checkbox"/> In Person