Medicine Hat School District No. 76

EMPLOYEE / ADULT (A2)
ACCIDENT/ILLNESS/INJURY REPORT

CONFIRMATION # ______________

This form must be submitted within 24 hours of the accident / illness / injury

Note: All Items and Sections noted in ***BOLD (*)*** are required fields and MUST be completed

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School: ______________________________ Date: ______________

Submitter's FIRST Name: ______________ Submitter's LAST Name: ______________

Phone Number: ______________ Email Address: ______________

Date of Accident: ______________ ***Time of Accident:*** ________ ❒ ***a.m.*** ❒ ***p.m.***

*Section ONE: LOCATION

❒ Administration Office
❒ Boot Room / Mud Room
❒ Classroom
❒ Cafeteria / Concession
❒ CTS Lab
❒ Drama / Arts / Theatre
❒ Exterior Stairs
❒ Gymnasium
❒ Hallway / Stairwell
❒ In Transit to or from School
❒ Locker Room
❒ Off-Site
❒ Playground
❒ Playing Field
❒ Other (specify)
❒ Science Lab
❒ Sidewalk
❒ Parking Lot
❒ Washroom

If Off-Site, state FACIILTY Name: ______________________________

Address: ______________________________

City: ______________ Postal Code: ______________

*Section TWO: ACCIDENT/INCIDENT INFORMATION

Description of Accident/Incident (detailed narrative)

____
____
____
____
____
____

****First Reported to:*** ***FIRST Name:*** ______________ ***LAST Name:*** ______________

❒ Lunch/Playground Supervisor ❒ Principal/Vice Principal ❒ Secretary/Support Staff ❒ Teacher
❒ Other (specify) ______________________________

Supervisor's FIRST Name: ______________ LAST Name: ______________

Supervisor's Title: (eg: Principal, Teacher, etc.) ______________

****Program:***

❒ Before / After School
❒ Field Trip
❒ Interscholastic Game/Practice
❒ Intramurals
❒ Physical Education
❒ Recess / Noon Hour
❒ Regular Classroom
❒ School Activity / Event
❒ School Assembly
❒ Science Lab
❒ Spare / Free Time / Study
❒ Other (specify) ______________
❒ Transition between classes
❒ Work Study

Equipment Involved: (if applicable)

❒ Art Equipment
❒ Athletic Equipment
❒ Chemicals
❒ Gymnastics Equipment
❒ Home Ec Equipment
❒ Playground Equipment
❒ Science Lab Equipment
❒ Shop Tools
❒ Other ______________
❒ Track & Field Equipment
❒ Playground Equipment

Provide more details (if applicable) ______________________________

Action(s) taken to prevent this sort of accident from happening in the future:

❐ CHECK if media has been involved or likely to be involved ❐ CHECK if legal action has been threatened # of people involved ________

Section THREE: INVOLVED PERSON

FIRST Name: ______________________ ***LAST Name:*** ______________________

Gender of person involved: ❐ Male ❐ Female ***Birthdate:*** (m/d/y) ______________

Status

❐ Caretaking ❐ Certificated Staff ❐ Support Staff ❐ Trades ❐ Other ______________

**Activity*

❐ Administration
❐ Caretaking
❐ Classroom Preparation
❐ Concession Duties
❐ Delivery/Transportation
❐ Field Trip
❐ General Office/SchoolWork
❐ Handling/Moving Equipment Books or Materials
❐ Instruction
❐ Leaving/Entering School
❐ Maintenance/Grounds Work
❐ Restraint of Student
❐ Supervision
❐ Walking
❐ Working with/assisting Special Needs Student

❐ Other (specify) ______________________________

**Parties Involved*

Is this a workplace violence issue? ❐ Yes ❐ No

If this is a workplace violence issue, please check parties involved:
❐ Staff to Parent ❐ Staff to Student ❐ Student to Staff ❐ Staff to Staff ❐ Parent to Staff
❐ Volunteer to Staff ❐ Other (specify) ______________________________

Covered by WCB ❐ Yes ❐ No

Is there a current hazard assessment for this position? ❐ Yes ❐ No

Has current assessment been reviewed? ❐ Yes ❐ No

*Accident/Incident Details

Was this person injured? ❐ Yes ❐ No ***Was first aid administered?*** ❐ Yes ❐ No

If first aid was administered, complete name of first aider: FIRST Name: ______________ LAST Name: ______________

Description of first aid administered: ______________________________

Qualified District first aider? ❐ Yes ❐ No

First aid qualification ❐ Advanced ❐ Emergency ❐ Nurse ❐ Standard ❐ Wilderness

Was a paramedic or physician called? ❐ Yes ❐ No If yes, was an ambulance used? ❐ Yes ❐ No

Name of physician or hospital/phone number: ______________________________

If no ambulance was used, identify method of transportation: ______________________________

If pre-existing medical condition exists, give details below, and diagnosis if available: ______________

Did this person lose time from work? ❒ Yes ❒ No First day of lost time (m/d/y) ______________________

Duties modified after accident? ❒ Yes ❒ No

*Injury / Illness Type (check applicable items)

- ❒ Allergic reaction
- ❒ Back/Spinal Injury
- ❒ Breathing difficulties/Asthma (no ambulance called)
- ❒ Broken bone(s) with long term affects (surgery required, pins or plates inserted)
- ❒ Broken or fractured bone(s)
- ❒ Chemical or other hazardous material Contact
- ❒ Concussion (possible concussion)
- ❒ Dislocated/separated joint
- ❒ Fainting, loss of consciousness
- ❒ Fatality
- ❒ Irritation of eye/skin
- ❒ Laceration (required stitches or medical attention)
- ❒ Permanent disability
- ❒ Seizure (short term – no ambulance called)
- ❒ Other (specify): ______________________
- ❒ Seizure (ambulance called)
- ❒ Serious breathing difficulties (ambulance called)
- ❒ Serious/major bleeding, bruising or swelling
- ❒ Severe sprain
- ❒ Severe wound (scarring or surgery)
- ❒ Tooth/teeth injury

*Cause of Injury (check applicable items)

- ❒ Accidental collision between participants
- ❒ Aggravation of pre-existing injury
- ❒ Assault
- ❒ Bite (animal/human/insect)
- ❒ Blow/hit/trip (caused by another person, accidental or intentional)
- ❒ Blow delivered by an object (eg: ball, bat)
- ❒ Body contact in the normal course of activity
- ❒ Carelessness on the part of the individual
- ❒ Fall/trip not due to observed factor
- ❒ Fall or loss of balance on apparatus
- ❒ Motor vehicle accident
- ❒ No clear apparent cause
- ❒ Obstruction on playing field
- ❒ Repetitive strain
- ❒ Site hazard
- ❒ Slip/fall (ice)
- ❒ Slip/fall (other)
- ❒ Strain or over exertion
- ❒ Working with/assisting Special Needs Student
- ❒ Other (specify): ______________________

*Body Part (check applicable items)

- ❒ Abdomen/Stomach
- ❒ Ankle
- ❒ Back
- ❒ Buttocks
- ❒ Cheek(s)
- ❒ Chest Area
- ❒ Chin
- ❒ Collarbone
- ❒ Ear(s)
- ❒ Elbow
- ❒ Eye(s)
- ❒ Finger(s)/Thumb
- ❒ Foot
- ❒ Other (specify): ______________________
- ❒ Groin
- ❒ Hand
- ❒ Head
- ❒ Hip
- ❒ Internal injuries
- ❒ Knee
- ❒ Lower arm
- ❒ Lower leg/calf
- ❒ Mouth
- ❒ Neck/throat
- ❒ Nose
- ❒ Shoulder
- ❒ Side/ribs
- ❒ Teeth
- ❒ Toes
- ❒ Upper arm
- ❒ Upper leg/thigh
- ❒ Wrist

*Section FOUR: WITNESS

Were there any witnesses? ❒ Yes ❒ No

Witness FIRST Name: ______________________ Witness LAST Name: ______________________

Address: ______________________ Postal Code: ______________________

Phone Number: ______________________ Witness Role (eg: teacher/supervisor/student): ______________________

Witness FIRST Name: ______________________ Witness LAST Name: ______________________

Address: ______________________ Postal Code: ______________________

Phone Number: ______________________ Witness Role (eg: teacher/supervisor/student): ______________________

***Report prepared by:** ______________________ **Position:** ______________________

***Principal's/Manager's Signature:** ______________________ **Date:** ______________________