



ACCIDENT / INCIDENT NOTIFICATION FORM

School Name/Location:	
-----------------------	--

BRIEF ACCOUNT OF INJURY

Details of Incident:	
<hr/> 	
Accident Date:	Accident Time:

ACTIVITY (GENERAL & DETAILED)

1. Chemical Use 2. Manual Handling, Lifting 3. Sports/Physical Education	4. Vehicle Use (Car, Bicycle, Bus, Other) 5. Machinery Use 6. Using Office Equipment 7. Curriculum Area	8. Fighting/Assault 9. Play General 10. Walking 11. Running, Jumping, Skipping 12. Accidental Contact by other Person 13. Other (Specify) _
--	--	---

ACCIDENT DESCRIPTION

1. Slip 2. Trip 3. Fall 4. Overexertion	5. Mental Stress 6. Collision 7. Crushing 8. Hit by Moving Object	9. Other (Specify) _
--	--	---



ACCIDENT SITE (Indicate CAMPUS, if more than one CAMPUS)

1. Sports Ground/Venue 2. Playground General 3. Playground Equipment 4. Classroom General 5. Chairs	6. Doors/Windows 7. Stairs/Steps 8. Paths/Walkways 9. Office Administration 10. Travel to / from School	11. Camp/Excursions 12. Other (Specify) ----- -----
---	---	--

STAFF ON DUTY

Name _____ _____
Number of Staff on Duty:

INJURED PERSON

Type: Student Staff Family Others	Name:	
Date of Birth:	Age:	Gender:
Address:		Telephone:

INITIAL ASSISTANCE BY PERSON



Type: Student Staff Family Others	Name:
---	-------

SEVERITY OF INJURY

INJURY:	1. First Aid (Returned to Class)	4. Hospital (Outpatient) Treatment
	2. First Aid (Sent Home)	5. Hospital (Inpatient) Treatment
	3. Doctor or Dental Treatment	6. Fatal

DOCTOR TREATED PATIENT FOR (If Applicable)

TREATMENT:	1. Amputation of any part of the body	7. The Loss of a bodily function
	2. Serious Head Injury	8. Serious lacerations (serious means "of Grave Aspect" or "Critical")
	3. Serious Eye Injury	9. Injury due to exposure to a substance (eg Gas Inhalation, Acid Exposure)
	4. Separation of skin from underlying tissue (eg Degloving/Scalping)	10. Other (Specify) _____
	5. Electric Shock	_____
	6. Spinal Injury	_____

NATURE OF INJURY

NATURE:	1. Fracture	6. Crushing/Amputations
	2. Dislocation	7. Bruises/Knocks
	3. Strains/Sprains	8. Dental Injuries
	4. Lacerations/Cuts	9. Other (Specify) _____
	5. Burns/Scalds	_____



LOCATION OF INJURY

LOCATION	1. Head (<i>Skull, Face, Jaws, Ears</i>) 2. Eyes 3. Neck 4. Trunk (<i>Chest, Abdomen, Buttock, pelvis, Spine</i>)	5. Arm (<i>Shoulder, Elbow, Forearm, Wrist, Hand, Finger, Thumb</i>) 6. Leg (<i>Hip, Thigh, Knee, Ankle, Foot, Toes</i>) 7. Internal 8. Multiple locations 9. Ear
----------	--	---

WITNESS DETAILS (Provide attachment if multiple witnesses)

Name:	Type: Student Staff Family Others ID (If Applicable):
Address:	Telephone:
Witness Statement: <hr/>	



PREVENTIVE ACTION PROPOSED OR TAKEN (For Staff members or Severe Accidents)

<ol style="list-style-type: none">1. No Preventative Action Taken/Intended2. Referred to the School's Safety/OHS or Risk Management Committee3. Referred to the School's Health and Safety Representative4. Review of Curriculum5. Review/Reinforce/Reiterate Procedures6. Review Systems7. Review the Environment	<ol style="list-style-type: none">8. Review Personal Protective Clothing/Item9. Review Equipment/Machinery Modifications10. Review Equipment/Machinery Maintenance11. Review/Reinforce/Reiterate Student Instructions12. Review Training Provisions
Staff Initial:	Principal Initial:
School's Insurer Contacted: Yes / No	

Date ____/____/____

Signature of Lead First Aider/Principal/Head of Campus _____