LISBON CENTRAL SCHOOL

6866 County Route 10
PO Box 39
Lisbon, New York 13658
315-3934951 Ext.151

Incident Report

Date_______________

NAME OF INJURED_______________________________________

NAME OF PARENT___________________________________ Phone_______________

DATE OF BIRTH_______________AGE_______GRADE_________

DATE INCIDENT OCCURRED____

BODY PART INJURED____

PLACE WHERE THE INCIDENT OCCURRED_________________________________
During: (check one)
Game [ ] Practice [ ] School Sponsored Activity [ ] Phys. Ed [ ] Classroom [ ] Hallway [ ] Other[ ]

STATE EXACTLY WHAT HAPPENED WHEN THE INCIDENT OCCURRED:
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Was the student supervised by an employee of the school district? ________
Who? ___________________________
Explain____
Was first aid given? ____
____
By Whom? ____

Signature and Title of person writing report _________________________ Date_________

Signature of Designated School Authority _________________________ Date_________
School Nurse