

**LYONS CENTRAL SCHOOL DISTRICT
ACCIDENT/INCIDENT PARENT NOTIFICATION FORM**

_____ was injured on _____ at _____ AM PM. Please be advised:

Place Where Injury Occurred:

- | | |
|---|--|
| <input type="checkbox"/> Home School | <input type="checkbox"/> Locker Area |
| <input type="checkbox"/> Away School | <input type="checkbox"/> Field/Court/Gym |
| <input type="checkbox"/> Bus/Bus stop | <input type="checkbox"/> Classroom/Hall |
| <input type="checkbox"/> Playground | <input type="checkbox"/> Cafeteria |
| <input type="checkbox"/> Other (specify): _____ | |

Body Injury Site:

- | | | | |
|------------------------------------|---|--------------------------------|----------------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> Ear | <input type="checkbox"/> Eye | <input type="checkbox"/> Nose |
| <input type="checkbox"/> Mouth | <input type="checkbox"/> Tooth | <input type="checkbox"/> Jaw | <input type="checkbox"/> Neck |
| <input type="checkbox"/> Chest/Rib | <input type="checkbox"/> Face | <input type="checkbox"/> Back | <input type="checkbox"/> Abdomen |
| <input type="checkbox"/> Genitals | <input type="checkbox"/> Extremity (specify below): | | |
| | <input type="checkbox"/> Left | <input type="checkbox"/> Right | |

Activity: _____

Sport: _____

- | | | | |
|-----------------------------------|--|-------------------------------|-------------------------------|
| <input type="checkbox"/> Varsity | <input type="checkbox"/> Girls | <input type="checkbox"/> Boys | <input type="checkbox"/> Coed |
| <input type="checkbox"/> JV | <input type="checkbox"/> Interscholastic | | |
| <input type="checkbox"/> Modified | <input type="checkbox"/> Intramural | | |

Type of Injury:

- | | |
|---|--------------------------------------|
| <input type="checkbox"/> Fall | <input type="checkbox"/> Altercation |
| <input type="checkbox"/> Collision | <input type="checkbox"/> Human Bite |
| <input type="checkbox"/> Other (specify): _____ | |

Observations:

- | | |
|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Memory problems |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Loss of consciousness |
| <input type="checkbox"/> Nausea/vomit | <input type="checkbox"/> Vision double/fuzzy |
| <input type="checkbox"/> Balance/dizzy | <input type="checkbox"/> Light/noise sensitivity |
| <input type="checkbox"/> Deformity | <input type="checkbox"/> Point of tenderness |
| <input type="checkbox"/> Discoloration | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Loss of sensation |
| <input type="checkbox"/> Slow speech | <input type="checkbox"/> Laceration |

Upper:

- Shoulder
- Arm
- Elbow
- Hand
- Wrist
- Finger # _____
(Thumb = #1)
(Pinky = #5)

Lower:

- Hip
- Thigh
- Knee
- Shin
- Ankle
- Foot
- Toe # _____
(Big toe = #1)
(Baby toe = #5)

WHAT HAPPENED?

Did all symptoms resolve? YES after _____ min./hr. NO

WAS THERE A TRANSFER OF BLOOD OR BODY FLUID BETWEEN PEOPLE? YES NO
(IMPORTANT: IF YES, PARENTS MUST CONTACT THE PRIVATE PHYSICIAN TODAY TO DISCUSS NEED FOR FURTHER CARE. ALL HEAD, NECK FACE, EYE, SPINE INJURIES OR OTHER INJURIES WITH PERSISTENT SYMPTOMS WARRANT DISCUSSION/EVALUATION BY OWN MD)

First Aid Rendered:

- | | | |
|-------------------------------|---|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Cleaned and Bandaged | <input type="checkbox"/> Rest and return to play/activity |
| <input type="checkbox"/> Ice | <input type="checkbox"/> Elastic Bandage | <input type="checkbox"/> Rest and restricted from further play/activity
(MANDATORY FOR ALL INJURIES WITH ANY SYMPTOMS UNTIL CLEARED BY OWN MD) |

Other (specify): _____

Student Was Discharged:

- | | |
|---|---|
| <input type="checkbox"/> Home on regular bus/car | <input type="checkbox"/> Transported by ambulance to hospital |
| <input type="checkbox"/> Picked up by parent/guardian | <input type="checkbox"/> Other (specify): _____ |

Recommendations:

- Please call me as needed at _____
- Please call the School Nurse on next school day at _____ to advise her of child's condition.
- Comments: _____

Even minor injuries need to be watched carefully. Please observe your child for further problems and call your own doctor as necessary. This form has been completed by a non-physician or non-nurse who has not diagnosed nor treated your child.

Signature/Title: _____ Date: _____

SCHOOL NURSE FOLLOW-UP

Comments: _____

Signature: _____ Date: _____

Copies to: School Nurse (original), Parents Yellow, Athletic Director Pink