

STUDENT INJURY/INCIDENT REPORT FORM AND/OR NON-DISTRICT PROPERTY DAMAGE OR INJURY SUSTAINED BY VISITORS OR THE PUBLIC —SAINT PAUL PUBLIC SCHOOLS—



Complete this form within 2-7 days of any incident involving bodily injury
email to > claims@spps.org

Do not use for motor vehicle accidents or SPPS employee injuries

This form is to be used by Saint Paul Public Schools staff only (SPPS or "District") to report student injuries and/or injuries or property damage sustained by visitors or the general public. It is important to note that this form should not be completed for student athlete injuries that occur during organized athletic activities. Submitting this form is not an admission of liability or negligence on the part of SPPS. Staff do not have the authority and are not to make any guarantees or commitments to parent(s) or guardian(s) or make any comments regarding acceptance of liability on behalf of the District in any communications. All personally identifiable and personal health information collected is considered CONFIDENTIAL.

1-STUDENT/INJURED PERSON (USE SEPARATE REPORT FORM FOR EACH INJURED PERSON)

NAME	DOB	AGE	GRADE	M F	CLASSIFICATION OF PERSON INJURED ENTER # IN BOX 1-SPPS STUDENT 3-PARENT/GUARDIAN 5- EMPLOYEE OF OTHER ENTITY CONTRACTED BY SPPS 2-NON SPPS STUDENT 4-VISITOR/PUBLIC 6- COMMUNITY ED PARTICIPANT 7-ATHLETE 8-OTHER	
SCHOOL STUDENT IS ENROLLED IN					ISD NAME OR ISD# (IF NOT SPPS/ISD 625)	
INVOLVED PERSON DETAILS	EYEGASSES ENTER # IN BOX 1-YES WEARS, HAD THEM ON 2-YES WEARS, THEY WERE OFF 3-DOES NOT WEAR GLASSES	TYPE OF SHOES ENTER # IN BOX 1-GYM SHOES 4-SANDALS 7-WORK BOOTS 10-OTHER 2-CASUAL TIE ON 5-HEELS 8-SNOW BOOTS 11-UNK 3-CASUAL SLIP ON 6-RAIN SHOES 9-NOT WEARING ANY	SPECIAL NEEDS AND/OR PHYSICAL LIMITATIONS DESCRIBE TYPE AND EXTENT			
PARENT/GUARDIAN NAME <small>(MAIN PERSON TO CONTACT)</small>			LANGUAGE IF NOT ENGLISH		HOW WAS CONTACT MADE? ENTER # IN BOX 1-PHONE CONTACT 2-PHONE VM 3- EMAIL 4-OTHER 5-NONE	
STREET ADDRESS		CITY ST, ZIP	EMAIL	PHONE	PHONE TYPE ENTER # IN BOX 1-CELL 2- HOME 3-WORK 4-OTHER	

2-LOCATION AND DETAILS OF INCIDENT ATTACH 1-2 PHOTOS OF LOCATION and/or EQUIPMENT

DATE OF INCIDENT	TIME	AM PM	LOCATION (NAME OF SCHOOL/SITE)	ADDRESS (INCLUDE STREET, CITY, ZIP)		
TYPE OF PREMISE ENTER # IN BOX 1-ATHLETIC FIELD 3-BAND/CHOIR RM 5-ART/SCI LAB 7-PLAYGROUND 9-HALL 11-STAIRS 13-PARKING LOT 15-OUTDOOR SPACE/LAB 17-POOL 2-AUDITORIUM 4-CLASSROOM 6-FACS/TECH ED RM 8-CAFETERIA 10-GYM 12-LIBRARY 14-BATHROOM 16-OFFICE 18-OTHER 19-UNK				SECURITY CAMERAS ENTER #s IN BOX 1-CAMERA 2-NO CAMERA 3-VIDEO CAPTURED 4-NO VIDEO		
SURFACE TYPE ENTER # IN BOX 1-ASPHALT 4-CARPET 7-GYM FLR: RUBBER 10-GRASS 13-WOOD CHIPS/MULCH 2-CONCRETE 5-TILE 8-GYM FLR: WOOD 11-MAT(S) 14-UNKNOWN 3-ICE/SNOW 6-GRAVEL 9-DIRT/SAND 12-SYNTHETIC SURFACE 15-OTHER			CONDITION ENTER # IN BOX 1-DRY 4-OILY/WAXY 7-UNEVEN 2-WET 5-SNOWY 8-OTHER 3-ICY 6-DIRTY/CLUTTERED		EQUIPMENT INVOLVED? (PLAYGROUND EQUIP, FURNITURE, SUPPLIES) IF YES, DESCRIBE (EX. MONKEY BARS, PLASTIC CHAIR, METAL SCISSORS)	
OCCURRED DURING ENTER # IN BOX 1-BEFORE SCHOOL 3-IN CLASS 5-AT RECESS 7-BETWEEN CLASSES 9-ATHLETIC PRACTICE/GAME 2-AFTER SCHOOL 4-DURING LUNCH 6-FIELD TRIP 8-COMMUNITY ED* 10-OTHER 11-UNKNOWN				*IF COMMUNITY ED, CLASS TYPE ENTER # IN BOX 1-ADULT BASIC ED 3-ADULT/YTH ENRICHMENT 5-YTH SUMMER 7-ECFE 9-DISC CLUB 2-ADULT SPEC NEEDS 4-GYMNASTICS/AQUATICS 6-DRIVER ED 8-PLANETARIUM 10-OTHER		
CLASS/COURSE/EVENT			LEAD TEACHER OR INSTRUCTOR NAME		EMAIL	
STUDENT-TO-TEACHER RATIO	DESCRIBE WHAT HAPPENED/CONTRIBUTED TO INCIDENT PROVIDE DETAILS (e.g., tripped on carpet & fell; poked eye w/metal scissors; two students collided in gym)					
# STUDENTS						
# SUPERVISORS <small>(INCL TEACHERS, EAs/TAs, VOLUNTEERS)</small>						
POLICE AT SCENE? CASE#	Y N	SAFETY INSTRUCTIONS GIVEN (e.g., "shoes off, no pushing"; safety rules posted in lab; describe verbal reprimands; consequences for breaking rules)			SAFETY MEASURES IN PLACE (e.g., "Wet Floor" signs in hall; orange safety cone over hole in athletic field; salt on icy steps)	

3-WITNESS(ES) IF ADDITIONAL SPACE IS NEEDED, EMAIL OR ATTACH SEPARATELY

FIRST/LAST NAME	EMAIL	PHONE	PHONE TYPE
			PHONE TYPE ENTER # IN BOX 1-CELL 2- HOME 3-WORK 4-OTHER
			PHONE TYPE ENTER # IN BOX 1-CELL 2- HOME 3-WORK 4-OTHER
			PHONE TYPE ENTER # IN BOX 1-CELL 2- HOME 3-WORK 4-OTHER

4-PROPERTY DAMAGE TO NON-SPPS PROPERTY

DESCRIBE PROPERTY DAMAGED	OWNER NAME	ADDRESS (INCLUDE STREET, CITY, ZIP)	PHONE	PHOTOS? ATTACH OR EMAIL	Y N
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INJURY DETAILS / TREATMENT / MEDICAL CONDITION **[CONFIDENTIAL]**

5-INJURY DESCRIPTION AND CARE

DESCRIBE THE INJURY **BE AS SPECIFIC AS POSSIBLE** (e.g., body part, left of right, severity [1" cut above lft eye]; unusual contributing factors)

INJURY CLASSIFICATION(S) ENTER 1 to 3 #s IN BOX (ex. 1,9,8) 1-BRUISE/BUMP 4-DISLOCATION 7-CONCUSSION 10-ALLERGIC REACTION 13-OTHER 2-BITE/STING 5-STRAIN/SPRAIN 8- CUT/LACERATION 11-PERSONAL MEDICAL 3-BURN/SCALD 6-FRACTURE 9-SCRAPE/ABRASION 12-CHIPPED/MISSING TOOTH	SYMPTOMS ENTER 1 to 3 #s IN BOX (ex. 1,4,10) 1-PAIN 4- ACHE/TENDERNESS 7- SHORTNESS OF BREATH 10-SWELLING 2-WEAKNESS 5- BLURRED VISION 8-FAINTING/UNCONSCIOUS 11-DIZZINESS 3-NUMBNESS 6- HEARING TROUBLE 9-TROUBLE SWALLOWING 12-RASH 13-OTHER
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6-HEALTH OFFICE TREATMENT

IMMEDIATE TREATMENT RENDERED BY STAFF ENTER 1-3 #s IN BOX 1-BANDAGE/GAUZE 3-CLEANED 5-TAPE/WRAP 7-OINTMENT 9-MASSAGE/MANUAL THERAPY 11-CPR/AED 2-R.I.C.E. METHOD 4-NSAIDs 6-ICE PACK 8-SPLINT/SLING 10-SKIN/EYE WASH 12-REFERRED 13-NONE 14-OTHER	FOLLOW-UP CARE ENTER # IN BOX 1-EMS/PARAMEDIC 3-SELF TRSPRT HOME (NON-MINOR) 5-HOSPITAL 7-NONE 2-PARENT/GUARDIAN HOME 4-CLNIC CARE 6-REFUSED CARE 8-OTHER
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ADDITIONAL TREATMENT NOTES **ACTION TAKEN, FIRST AID MEASURES**

7-MEDICAL CARE RECEIVED / CURRENT CONDITION

NAME OF CLINIC, HOSPITAL, DENTIST, EMS/PARAMEDIC	CITY	ATTENDING PROVIDER'S NAME
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CURRENT CONDITION/DIAGNOSIS/PROGNOSIS **INCL SUGERIES, FOLLOW-UP CARE REQUIRED, LENGTH CARE IS NEEDED, ETC.**

DID STUDENT MISS SCHOOL? IF YES, ENTER TIME/DAY(S)/DATE(S)	# HRS	# DAYS	DATES STUDENT MISSED SCHOOL	SPECIFY REASON(S) MISSED (e.g., surgery, dr appt, etc.)
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RESTRICTED SCHOOL ACTIVITY? IF YES, EXPLAIN	LENGTH OF TIME RESTRICTED
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8- FAMILY/PARENT/GUARDIAN CONTACT SUMMARY

HAS FAMILY CONTACTED THE SCHOOL ABOUT MEDICAL CARE, EXPENSES, OR OTHER?	Y N	NAME OF FAMILY MEMBER	RELATION ENTER # IN BOX 1-DAD 2-MOM 3-BROTHER 4-SISTER 5-GUARDIAN 6-OTHER	CONTACT TYPE ENTER # IN BOX 1-EMAIL 2- PHONE 3-IN PERSON 4-OTHER
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SUMMARY OF COMMUNICATION/DISCUSSION

***** ATTACH HEALTH OFFICE VISIT REPORT, IF AVAILABLE *****

SPPS PERSONNEL COMPLETING FORM (MUST BE COMPLETED BY SPPS STAFF ONLY)

NAME	PHONE	CELL? Y N	EMAIL	DATE COMPLETED
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