STUDENT/VISITOR INCIDENT REPORT

School District: West Seneca Central Schools School Name:

Student Name: _____Date: _____/_____/_____ Time: _____ (am/pm)

Home Address/Telephone: _____ DOB ____/____/____
Street City, State, Zip

Description of Location: _____ Grade: _____

ALLEGED INCIDENT INFORMATION

Reported By: _____ Date: _____/_____/_____ Time: _____

(am/pm) Describe How the Alleged Incident Occurred: _____

_____

Person Supervising Student: _____

Please Describe Alleged Injury *(Include part of body):* _____

Name/Address/Telephone of any witnesses *(Please indicate if none):*_____

Was first aid rendered? YES _____ NO _____ If Yes, by whom/date/time:

Did student remain in school remainder of day/activity? YES _____ NO _____ Describe first aid:

Did student receive medical attention by a doctor or hospital? YES _____ NO _____ If Yes, describe medical attention. If unknown, please state:

_____

Name/Address/Telephone # of physician or hospital:

EMERGENCY CONTACT INFORMATION

Person Contacted/Relationship: _____

Address: _____ Telephone: _____

Contacted by: _____ Date: _____/_____/_____ Time:(am/pm) _____

If Emergency Contact Was Not Contacted, Please State Reason: _____

Completed by Name: _____ Date ____/____/____ Title:

Reviewed by Name: _____ Date ____/____/____ Title: