

ELEANOR MANN SCHOOL OF NURSING INCIDENT REPORT

Student Name: _____ UA ID #: _____
 Local Address: _____ Phone: _____
 Home Address: _____
 Time Accident Occurred: _____ a.m. / _____ p.m. Date: _____
 Place of Accident: _____ Number of People Involved: _____

PART OF BODY INJURED

DESCRIPTION OF THE ACCIDENT

Abdomen	Foot
Ankle	Hand
Arm	Head
Chest	Knee
Ear	Leg
Elbow	Mouth
Eye	Nose
Face	Tooth
Finger	Wrist
Other (specify): _____	

How did the accident happen?
 What was the student doing?

 Student's Signature

NATURE OF INJURY

DEGREE OF INJURY

Abrasion	Laceration	Non-Disability
Bite	Needle Stick	Temporary Disability
Bruise	Poisoning	Permanent Impairment
Concussion	Puncture	Death
Cut	Scratches	
Dislocation	Shock (el.)	
Fracture	Sprain	
Other (specify): _____		

Faculty/Preceptor in charge when accident occurred: _____
 Present at scene of accident: YES _____ NO _____

IMMEDIATE ACTION TAKEN

NAME

First-Aid Treatment	By: _____
Campus Police Notified	By: _____
EMS Notified (911)	By: _____
Sent to Student Health Ctr	By: _____
Sent Home	By: _____
Sent to Physician	By: _____
Physician's Name	
Sent to Hospital (ER)	By: _____
Hospital Name	

Was a parent or other individual notified? YES _____ NO _____ When _____ How _____

Name of Individual(s) notified: _____

By whom? _____

Witnesses: _____ Address/Phone _____

_____ Address/Phone _____

REMARKS

What recommendations do you have for preventing accidents of this type? _____

 Student Signature

 Faculty Signature

 EMSON Director Signature

Cc: Student File

COEHP Administration

Hospital Risk Management Dept.