Student Injury Report Form

Frederick County Public Schools
191 South East Street
Frederick, Maryland 21701

Clear Form

Form #400-28F
Regulation 400-28
March 2023

If a student requires medical attention due to their injury, please call the Fiscal Services, Senior Executive Secretary at 301-644-5008

School Name: ______________________ Student Name: ______________________

Student ID: __________ Grade: ______ Birthdate: __________ Sex: __________

Parent/Guardian: ______________________

Home Address: ______________________

DATE OF INJURY: __________ TIME OF INJURY: __________ a.m. ☐ p.m. ☐

LOCATION OF INJURY

☐ Playground ☐ Athletic Field ☐ Auditorium
☐ Classroom ☐ Hallway ☐ Gymnasium
☐ Cafeteria ☐ Laboratory ☐ Stairs
☐ Locker Room ☐ Bus ☐ CTC
☐ Other,
Explain:

NATURE OF INJURY

☐ Abrasion ☐ Cut ☐ Scratch
☐ Bruise ☐ Fracture ☐ Sprain
☐ Burn ☐ Laceration
☐ Concussion ☐ Puncture
☐ Other,
Explain:

PART(S) OF BODY INJURED

☐ Ankle ☐ Face ☐ Knee
☐ Arm ☐ Finger ☐ Leg
☐ Back ☐ Foot ☐ Mouth
☐ Elbow ☐ Hand ☐ Nose
☐ Eye ☐ Head ☐ Tooth
☐ Other, ☐ Wrist
Explain:

DESCRIPTION OF THE INJURY

STATEMENT #1
INJURED PARTY

Statement from injured party:

STATEMENT #2
SCHOOL BASED PERSON WITH KNOWLEDGE OF WHAT OCCURRED

Name: ______________________ Phone: __________

Position: ______________________

☐ FCPS Employee ☐ FCPS Student ☐ Parent /Guardian
☐ Visitor ☐ *HRT Nurse

If you saw the injury occur, please describe what you observed:

*Healthroom comments (from Healthroom report):

List any other witnesses you recall who were present:

SUPERVISION OF STUDENT

Who was supervising the student when the injury occurred?

Name: ______________________ Position: ______________________

ACTION TAKEN

First-aid Treatment
By (Name): ______________________ Title: ______________________

Sent to School Nurse
By (Name): ______________________ Title: ______________________

Sent Home
By (Name): ______________________ Title: ______________________

Sent to Physician
By (Name): ______________________ Title: ______________________
Name of Physician: ______________________

Sent to Hospital
By (Name): ______________________ Title: ______________________
Name of Hospital: ______________________

Parent Notified
When?: ______________________ How?: ______________________
Name of Individual Notified: ______________________ Relationship to Student: ______________________
By Whom? (Name): ______________________ Position: ______________________

Completed by: ______________________ **Date:** ______________________