Clear Form

Student Injury Report Form

FOR BUS DRIVERS ONLY

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

Fiscal Services Division

Form #009-F04
August 2025

If a student requires medical attention due to their injury, please call the Fiscal Services, Executive Assistant at 240-586-7402.

School Name: _____ Student Name: _____

Student ID: _____ Grade: _____ Birthdate: _____ Sex: _____

Parent/Guardian: _____ Phone No: _____

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:** _____