Lewiston-Porter Central School District

One Purpose. Your Pathway. Our Promise.

ACCIDENT REPORTING FORM

FULL NAME: ____

ADDRESS: ______________________________ PH: ______________

SOC. SEC. NO.: ______________ DATE OF BIRTH: __________

DATE OF ACCIDENT: _________ TIME OF ACCIDENT: ________ AM ___ PM ___

REASON FOR BEING ON CAMPUS: (*EX: Community Ed class, Athletic event*): ______________

____

WHERE DID ACCIDENT OCCUR: (*EX: High School, Hallway)*______________________

____

TYPE OF INJURY AND BODY PART: *(EX: laceration, left hand)*__________________

____

HOW DID INJURY OCCUR: *(EX: Tripped and fell)* ______________________

____

WITNESSES:
FULL NAME: ____

ADDRESS: ______________________________ PH: ______________

FULL NAME: ____

ADDRESS: ______________________________ PH: ______________

MEDICAL ATTENTION REQUIRED/RECEIVED? NO ( ) YES ( )
IF YES: DATE: __________ Doctor's office ( ) ER/Immediate Care Center ( )

NAME OF MEDICAL FACILITY: ______________________________________

ADDRESS: ____

PHYSICIANS NAME: ______________________________________

This form is to be filled out completely and submitted within twenty-four (24) hours to:
Scott Hoot, Interim Assistant Superintendent for Administrative Services
Lewiston-Porter Central School District
Office of Administrative Services
4061 Creek Road, Youngstown, NY 14174