



INCIDENT REPORT

Please type or print in block letters. Attach an additional sheet if more space is required.

1 GENERAL This section MUST be completed in full

NAME OF SCHOOL <u>South Delta Secondary</u>		S.D. NUMBER <u>37</u>	FACILITY CODE <u>037</u>	SCHOOL PHONE NO. <u>604-943-7407</u>
NAME OF SUPERVISOR/TEACHER/INSTRUCTOR INVOLVED		DATE OF INCIDENT Y M D		TIME OF INCIDENT: _____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
DESCRIPTION OF HOW INCIDENT OCCURRED				
WITNESSES - <i>If more than 2 witnesses, attach an additional sheet.</i>			LOCATION OF INCIDENT:	
1. NAME OF WITNESS			01 <input type="checkbox"/> BASEMENT	
ACTIVITY OF WITNESS AT TIME OF INCIDENT			02 <input type="checkbox"/> CAFETERIA/LUNCHROOM	
2. NAME OF WITNESS			03 <input type="checkbox"/> CLASSROOM	
ACTIVITY OF WITNESS AT TIME OF INCIDENT			04 <input type="checkbox"/> SHOPS/LABS/KITCHENS	
			05 <input type="checkbox"/> DOORS/ENTRANCE AREAS	
			06 <input type="checkbox"/> DORMITORIES	
			07 <input type="checkbox"/> GYMNASIUM/AUDITORIUM	
			08 <input type="checkbox"/> HALLWAY/LOCKERS	
			09 <input type="checkbox"/> LIBRARY/OFFICE/	
			10 <input type="checkbox"/> LOUNGE/STUDY ROOM	
			11 <input type="checkbox"/> PARK/GROUNDS	
			12 <input type="checkbox"/> PLAYING FIELDS	
			13 <input type="checkbox"/> PLAYGROUND EQUIPMENT	
			14 <input type="checkbox"/> POOL	
			15 <input type="checkbox"/> RINK	
			16 <input type="checkbox"/> SIDEWALKS/ROADS OFF	
			17 <input type="checkbox"/> WITHIN GROUNDS	
			18 <input type="checkbox"/> FACILITY PROPERTY	
			19 <input type="checkbox"/> STAIRS WITHIN BUILDING	
			20 <input type="checkbox"/> STAIRS/SIDEWALKS	
			21 <input type="checkbox"/> WITHIN GROUNDS	
			22 <input type="checkbox"/> WASHROOMS/CHANGING	
			23 <input type="checkbox"/> ROOMS/SHOWERS	
			24 <input type="checkbox"/> OTHER - <i>Please explain:</i>	
<input type="checkbox"/> THERE WERE NO WITNESSES TO THE INCIDENT				

2 A Complete this section for Bodily Injury, Other Party Damage

NAME OF PERSON INVOLVED IN INCIDENT		AGE	GENDER - For statistical purposes only <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	GRADE	NIGHT SCHOOL <input type="checkbox"/> YES <input type="checkbox"/> NO
HOME ADDRESS		CITY		PROVINCE	POSTAL CODE
STATUS <input type="checkbox"/> STUDENT <input type="checkbox"/> VISITOR <input type="checkbox"/> OTHER - <i>Please explain:</i>					
PARENT/GUARDIAN/EMERGENCY CONTACT NAME			WAS THE CONTACT PERSON NOTIFIED? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If YES, please explain how:</i>		
INSTRUCTIONS/COMMENTS OF PARENT/GUARDIAN/EMERGENCY CONTACT					
FIRST AID TREATMENT REQUIRED? <input type="checkbox"/> YES <input type="checkbox"/> NO		TYPE OF TREATMENT PROVIDED?		BY WHOM?	
WAS HOSPITAL CARE PROVIDED? <input type="checkbox"/> YES <input type="checkbox"/> NO		<i>If YES, please identify type of care:</i> <input type="checkbox"/> ADMITTED <input type="checkbox"/> EMERGENCY VISIT ONLY		TREATMENT? (if known)	
NATURE OF INJURY/DAMAGE - <i>Check one only</i>		BODY AREA INJURED - <i>Check one only</i>		HOW WAS THE PATIENT TRANSPORTED? <input type="checkbox"/> AMBULANCE <input type="checkbox"/> OTHER: <input type="checkbox"/> PRIVATE VEHICLE	
01 <input type="checkbox"/> BRUISE/ABRASION/SWELLING		01 <input type="checkbox"/> ARMS/SHOULDER/ELBOW		01 <input type="checkbox"/> MULTIPLE AREAS	
02 <input type="checkbox"/> BURN		02 <input type="checkbox"/> CHEST/ABDOMEN/PELVIS		02 <input type="checkbox"/> NECK	
03 <input type="checkbox"/> CONCUSSION(SUSPECTED)		03 <input type="checkbox"/> EYES		03 <input type="checkbox"/> NO INFORMATION	
04 <input type="checkbox"/> CRUSHED		04 <input type="checkbox"/> FACE		04 <input type="checkbox"/> SPINE/BACK	
05 <input type="checkbox"/> DENTAL DAMAGE		05 <input type="checkbox"/> FEET/TOES		05 <input type="checkbox"/> TEETH/MOUTH	
06 <input type="checkbox"/> DISLOCATION		06 <input type="checkbox"/> FINGERS/HANDS/WRISTS		06 <input type="checkbox"/> OTHER - <i>Please explain:</i>	
07 <input type="checkbox"/> FATALITY/DEATH		07 <input type="checkbox"/> HEAD/FOREHEAD			
08 <input type="checkbox"/> FRACTURE		08 <input type="checkbox"/> LEGS/KNEES/ANKLES			
09 <input type="checkbox"/> IMBEDDED OBJECT					
CAUSE OF INJURY OR DAMAGE - <i>Check one only</i>		ACTIVITY AT TIME OF INCIDENT - <i>Check one only</i>			
*01 <input type="checkbox"/> ASSAULT-NO WEAPON (INTENTIONAL)		01 <input type="checkbox"/> CLASSROOM		08 <input type="checkbox"/> TRAVEL TO OR FROM FACILITY	
*02 <input type="checkbox"/> ASSAULT-WITH WEAPON (INTENTIONAL)		02 <input type="checkbox"/> BETWEEN CLASSES		09 <input type="checkbox"/> UNORGANIZED SPORTS	
03 <input type="checkbox"/> CHOKING/SUFFOCATION		03 <input type="checkbox"/> EXTRA-CURRICULAR (i.e. CLUB)		10 <input type="checkbox"/> WORK PLACEMENT	
04 <input type="checkbox"/> DROWNING		04 <input type="checkbox"/> OUT-OF-CLASS		11 <input type="checkbox"/> MAINTENANCE ACTIVITY	
05 <input type="checkbox"/> EXPOSURE TO FLAME/ELECTRICITY/HOT OR CAUSTIC SUBSTANCE		05 <input type="checkbox"/> SCHOOL BUS ACCIDENT		12 <input type="checkbox"/> OTHER - <i>Please explain:</i>	
06 <input type="checkbox"/> FALL AT SAME HEIGHT		06 <input type="checkbox"/> RECESS/PRE-OR POST CLASS/NOON HOUR			
07 <input type="checkbox"/> FALL FROM DIFFERENT HEIGHT		07 <input type="checkbox"/> STRUCK AGAINST PERSON			
08 <input type="checkbox"/> FATIGUE/OVER EXERTION		08 <input type="checkbox"/> STRUCK/CRUSHED BY/AGAINST OBJECT			
09 <input type="checkbox"/> FOREIGN BODY		09 <input type="checkbox"/> OTHER - <i>Please explain:</i>			
*10 <input type="checkbox"/> HORSEPLAY (NO INTENT TO INJURE)		*10 <input type="checkbox"/> SEXUAL ASSAULT (ALLEGATIONS INCLUDED)			
*List names of others involved:					

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FULL NAME OF PERSON COMPLETING REPORT - <i>Please print</i>		TITLE	SIGNATURE	DATE SIGNED Y M D
FULL NAME OF ADMINISTRATOR - <i>Please print</i>		SIGNATURE	DATE SIGNED Y M D	