

# CONFIDENTIAL SCHOOL INCIDENT INVESTIGATION

**FOR INTERNAL USE ONLY:**

**Do Not Copy or Distribute**

**SEND COMPLETED REPORT TO DISTRICT OFFICE**

**ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE STRICTLY CONFIDENTIAL  
ATTORNEY/CLIENT PRIVILEGE**

<b>District Name:</b>	Calaveras Unified School District	<b>School/Site:</b>	
<b>Name</b> (Last, First, M.I.):		<input type="checkbox"/> Student	<input type="checkbox"/> Non-Student
<b>Home Address:</b> Street, City, State, Zip		<b>Grade</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <span style="float: right;">Date of Birth</span>
<b>Home Phone No.:</b>		<b>Date of Incident:</b>	<b>Time:</b>
<b>Report to Whom?</b>		<b>Date Reported:</b>	<b>Time:</b>

## DETAILS OF INCIDENT

Exact Location of Incident

Did incident involve other student(s) or non-student(s)?  Yes  No IF "YES," GIVE NAME(S):

**DESCRIBE HOW THE INCIDENT OCCURRED IN DETAIL** (ATTACH ADDITIONAL SHEET OR REPORT IF NECESSARY)

WAS EQUIPMENT OR MACHINERY INVOLVED? (PLAYGROUND, INDUSTRIAL ARTS, ETC.)  Yes  No IF "YES," NOTE ANY DEFICIENCIES

WAS A RULE OR PROCEDURE VIOLATED? EXPLAIN (Include horseplay)

Full Name of Teacher, Teacher's Aide, etc., for injured student	Title of Person (Teacher, Aide, etc.)	Present at time of incident? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Name of Witness	Address	Phone	Status: <input type="checkbox"/> Teacher <input type="checkbox"/> Parent <input type="checkbox"/> Student <input type="checkbox"/> Statement Attached: <input type="checkbox"/> Yes <input type="checkbox"/> No
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Name of Witness	Address	Phone	Status: <input type="checkbox"/> Teacher <input type="checkbox"/> Parent <input type="checkbox"/> Student <input type="checkbox"/> Statement Attached: <input type="checkbox"/> Yes <input type="checkbox"/> No
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Name of Witness	Address	Phone	Status: <input type="checkbox"/> Teacher <input type="checkbox"/> Parent <input type="checkbox"/> Student <input type="checkbox"/> Statement Attached: <input type="checkbox"/> Yes <input type="checkbox"/> No
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Parent/Guardian Name	Date/Time Contacted
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Parent Comments:

NATURE OF INJURY	INJURED PART OF BODY
<input type="checkbox"/> Abrasion <input type="checkbox"/> Fracture <input type="checkbox"/> Sprain <input type="checkbox"/> Concussion <input type="checkbox"/> Contusion <input type="checkbox"/> Cut <input type="checkbox"/> Dislocation <input type="checkbox"/> Internal <input type="checkbox"/> Other - Explain below:	<input type="checkbox"/> Left Side <input type="checkbox"/> Right Side <input type="checkbox"/> Abdomen <input type="checkbox"/> Arm <input type="checkbox"/> Back <input type="checkbox"/> Chest <input type="checkbox"/> Eye <input type="checkbox"/> Face <input type="checkbox"/> Finger <input type="checkbox"/> Foot <input type="checkbox"/> Hand <input type="checkbox"/> Head <input type="checkbox"/> Leg <input type="checkbox"/> Neck <input type="checkbox"/> Other pain/discomfort - Explain below:

First Aid Treatment Given: Name of person who administered First Aid:

Disposition  Return to Class  Home  Doctor  911/Hospital

Other Transported By:

<b>REPORT PREPARED BY</b>	<b>TITLE</b>	<b>PHONE NUMBER</b>	<b>DATE PREPARED</b>
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**SITE ADMINISTRATOR SIGNATURE**

**CONFIDENTIAL ATTORNEY/CLIENT PRIVILEGE**