

Howell Public Schools
Visitor Accident Report
(To be made out within 24 hours of accident)

Name _____ Address _____

Date of Accident _____ Time _____ Date Reporting _____

Phone _____ Male [] Female []

Location of Accident _____
(e.g. H.H.S. Parking Lot, HWMS Media Center, etc.)

Description of Incident (Be Specific) _____

Nature of Injury _____
(Cut, Bruise, Swelling, etc.)

Witnesses If None []

1. Name _____ Address _____

Phone _____

2. Name _____ Address _____

Phone _____

Signature of Responsible Adult in Area _____

Action Taken:

Taken Home No [] Yes []

Taken to Hospital No [] Yes []

Taken to Private Physician No [] Yes []

Other _____

Other Individual(s) Notified:

Name _____ Relationship _____

Name _____ Relationship _____

Signature of Person Administering First Aid _____

Follow-Up Information:

Date _____

Comments _____

Signature of Administrator _____