



STATE OF HAWAII
DEPARTMENT OF EDUCATION
Office of Business Services
P.O. Box 2360
Honolulu, Hawaii 96804

STUDENT ACCIDENT REPORT

Form No. 411

School James B. Castle H.S. School Code # _____ Accident Report # _____
Report Filled Out By _____ Position _____ Date of Report ____/____/____
Month Day Year

A. STUDENT INVOLVED

Name _____
(Last) (First) (Initial)
Grade _____ Age _____ Sex _____ Reg. _____ Spe'l _____
Accident Date ____/____/____ Time ____ AM ____ PM
Month Day Year

E. PART OF BODY INJURED

- | | | |
|----------------------------------|---------------------------------|--|
| <input type="checkbox"/> Abdomen | <input type="checkbox"/> Eye | <input type="checkbox"/> Knee |
| <input type="checkbox"/> Ankle | <input type="checkbox"/> Face | <input type="checkbox"/> Leg |
| <input type="checkbox"/> Arm | <input type="checkbox"/> Finger | <input type="checkbox"/> Teeth |
| <input type="checkbox"/> Back | <input type="checkbox"/> Foot | <input type="checkbox"/> Wrist |
| <input type="checkbox"/> Chest | <input type="checkbox"/> Hand | <input type="checkbox"/> Other (Specify) |
| <input type="checkbox"/> Elbow | <input type="checkbox"/> Head | _____ |

B. LOCATION OF ACCIDENT

- | | |
|--|---|
| <input type="checkbox"/> Agriculture Field | <input type="checkbox"/> Playground |
| <input type="checkbox"/> Athletic Field | <input type="checkbox"/> Shop |
| <input type="checkbox"/> Cafeteria | <input type="checkbox"/> Stairs/Steps |
| <input type="checkbox"/> Classroom | <input type="checkbox"/> Swimming Pool |
| <input type="checkbox"/> Gymnasium | <input type="checkbox"/> Walkway, Outdoor |
| <input type="checkbox"/> Hallway | <input type="checkbox"/> Other (Specify) |
| <input type="checkbox"/> Parking Area | _____ |

F. IMMEDIATE ACTION TAKEN

- First Aid By _____
 Sent to Health Aide By _____
 Sent Home By _____
 Sent to Doctor By _____
 Doctor's Name _____
 Sent to Hospital By _____
 Hospital's Name _____
 By What Means _____

C. ACTIVITY INVOLVED IN ACCIDENT

- | | |
|---|--|
| <input type="checkbox"/> Athletics | <input type="checkbox"/> Play/Free Time |
| <input type="checkbox"/> Classroom | <input type="checkbox"/> Transportation/Trip |
| <input type="checkbox"/> Physical Education | <input type="checkbox"/> Other (Specify) |
| | _____ |

G. PERSON NOTIFIED

- Parent Guardian Friend
 Name of Person Notified _____
 By Whom Notified _____
 By What Means _____
 If so, how long after injury _____

D. APPARENT NATURE OF INJURY

- | | |
|---|---|
| <input type="checkbox"/> Abrasion | <input type="checkbox"/> Poisoning |
| <input type="checkbox"/> Bruise/Bump | <input type="checkbox"/> Puncture |
| <input type="checkbox"/> Burn | <input type="checkbox"/> Shock (Electrical) |
| <input type="checkbox"/> Cut/Laceration | <input type="checkbox"/> Sprain |
| <input type="checkbox"/> Dislocation | <input type="checkbox"/> Sting |
| <input type="checkbox"/> Fracture | <input type="checkbox"/> Other (Specify) |
| <input type="checkbox"/> Head Injury | _____ |

H. WITNESS TO ACCIDENT

- (Additional witnesses may be attached)
- Name _____ Staff
 Student
- Name _____ Staff
 Student
- First Staff Person at Scene of Accident _____

I. DESCRIPTION OF ACCIDENT

(How did accident happen? What was student doing? Additional information may be attached.)

Principal's/VP's Signature _____

Date _____