ST. VRAIN
academic excellence by design

VISITOR INJURY REPORT

INSTRUCTIONS: Please promptly fill out this report. Send to Risk Management Services within 48 hours, even if some information is not yet available. A Supplemental report should be sent if more information becomes available later on. Also, please notify **Claims and Safety Specialist** of any corrective actions or repairs made.

Date of Report _____ School/Dept. Reporting _____

VISITOR INFORMATION:

Visitor's Name _____ Date of Birth ____/____/____ Sex _____ Age _____
Home Address _____ City _____ Zip Code _____
Home Phone _____ Work Phone _____ Cell Phone _____
Name of Parents/Guardian (if applicable) _____ Phone _____

INJURY INFORMATION

Date of Injury _____ Time of Injury _____ a.m. p.m. Date reported by injured _____
What object/substance/person may have contributed to injury? _____
Nature of Injury: ☐ Abrasion ☐ Bruise ☐ Burn ☐ Head Injury ☐ Laceration/Cut ☐ Sprain/Strain
☐ Fracture ☐ Dislocation ☐ Chemical Spill/Splash ☐ Other _____
Body Part Injured: _____
Extent of Injury: ☐ Minor ☐ Moderate ☐ Severe

Describe in detail how the injury occurred: _____

Name of Witness(es):_____ Phone_____ ☐ Employee ☐ Student ☐ Visitor
_____ Phone_____ ☐ Employee ☐ Student ☐ Visitor
Safety Issue? (describe): _____

INCIDENT RESPONSE

☐ No Care Necessary
☐ First Aid Given On Site ☐ Treated By: _____
☐ 911/Ambulance/EMT Called
Did injured go to doctor? ☐ Yes ☐ No Name of doctor:_____
Did injured go to hospital? ☐ Yes ☐ No Name of hospital: _____
Care of injury (specify care given and by whom): _____

Supplemental report to follow: ☐ Yes ☐ No

SIGNATURES:

Person completing report _____ Date _____Principal/Supervisor _____

Risk Management Review _____ Date _____

RMS 7/15