

DIOCESE OF BELLEVILLE
STUDENT INJURY REPORT

(Rev. 7/2018)

TODAY'S DATE: _____

NAME OF PERSON REPORTING: _____ TELEPHONE# _____

SCHOOL / CITY: _____

ADDRESS: _____ TELEPHONE# _____

DATE OF INCIDENT: _____ TIME: _____ A.M./P.M.

NAME OF INJURED: _____ AGE & GRADE _____

ADDRESS: _____ TELEPHONE# _____

IF A MINOR, NAMES(S) OF PARENTS: _____

WERE PARENTS NOTIFIED? ___ YES ___ NO

NATURE OF INJURY: _____

HEAD INJURY? ___ YES ___ NO IF YES, CONCUSSION PROTOCOL FOLLOWED? ___ YES ___ NO

DESCRIPTION OF INCIDENT: _____

(Use other side if additional space is required)

NAME(S) OF WITNESSES: _____

ADDRESS: _____ TELEPHONE# _____

WAS INJURED PARTY TAKEN TO HOSPITAL OR URGENT CARE FACILITY? ___ YES ___ NO

IF YES, NAME & LOCATION OF FACILITY: _____

--PLEASE COMPLETE THIS FORM AS SOON AS POSSIBLE AFTER INCIDENT--

EMAIL OR FAX TO:

OFFICE OF FACILITIES & RISK MANAGEMENT – Attn: Deacon Bill Johnson

E-MAIL – bjohnson@diobelle.org FAX - (618) 233-1696

AND

OFFICE OF EDUCATION – Attn: Ms. Mary Fournie

E-MAIL – mfournie@diobelle.org FAX – 618-235-7115