Educational Service Unit 8 - Incident Report

ENTIRE FORM TO BE COMPLETED BY SCHOOL NURSE

Date _____

Employee

Name _____

Position _____

Nurse

Name _____

Position _____

Incident

Date _____ Time _____

Location _____

Description of Incident

Nurse's Assessment

Witnesses – List Names

_____ _____ _____

_____ _____ _____

Action to be taken – respond yes or no to EACH question

Emergency Room Visit ☐ Yes ☐ No

Medical Clinic Visit ☐ Yes ☐ No

File Work Comp Claim ☐ Yes ☐ No

Remained @ work ☐ Yes ☐ No

Other additional actions or comments on above responses

By signing this document, you acknowledge that you have read and understood the information contained herein

_____ _____

Employee **Nurse**

_____ _____

Date **Date**

Return a copy of this form to Elleah Wiebelhaus @ the central office. ewiebelhaus@esu8.org