ACCIDENT REPORT FORM

Victor Valley COMMUNITY COLLEGE

Date of Accident_____ Time of Accident _____am / pm

Name _____ Student I.D. #_____

Phone # _____ D.O.B._____

Address _____City _____Zip_____

Emergency Contact_____ Phone ( )_____

Insurance Company *(complete if covered by insurance; otherwise write "None")*_____

_____

PLACE OF ACCIDENT

Classroom (specify)_____ VVC Athletic Field_____ VVC Gym _____ VVC Courts _____

Other Location (if Off Campus, specify)_____

NATURE OF INJURY

Bite ☐ Bruise ☐ Burn ☐ Concussion ☐ Cut ☐ Dislocation ☐ Fracture ☐ Poisoning ☐

Puncture ☐ Scratches ☐ Sprain ☐ Strain ☐ Other (specify)_____

DESCRIPTION OF ACCIDENT

What was the cause of the accident? How did it happen? *(List specifically unsafe acts and unsafe existing conditions. Specify any tool, machine or equipment involved).*

ACTION TAKEN

Ice ☐ Bandage ☐ Crutches ☐ Eye Wash ☐ Sling ☐ Splint ☐ Wrapped ☐

Other (specify) _____

Was a parent or other individual notified? No ☐ Yes ☑ When?_____ How?_____

Name of individual notified_____ By Whom?_____

Witnesses: Name_____ Phone_____

Name_____ Phone_____

Sent to Hospital (name)_____Referral to Physician_____

Refused Treatment_____

Signed_____ **Signed**_____

(Injured Person) **(VVC Employee)**

Date _____ **Date** _____

Rev. 12/08

****Send Form to Administrative Svcs.**