CHESTERFIELD COUNTY GOVERNMENT AND PUBLIC SCHOOLS

Log/Case Number:

*RM USE ONLY*

***CITIZEN INJURY REPORT***

## PART I. CITIZEN INFORMATION

Name of Injured:

_____
Last First Middle Initial

Injured's Address:

_____
Street City State Zip Code

Telephone Numbers: (Day Time) _____ (Home) _____

| Date of Injury: | Time of Injury: _____ ☐ a.m. ☐ p.m. | Date of Birth: |
|---|---|---|
| | | Male _____ Female _____ |

Name of Parent or Guardian: (If injured under 18 years old)

_____
Last First Middle Initial

_____
Street City State Zip Code

## PART II. PART OF BODY INJURED (Please mark area where injury occurred.)

| | | | | |
|---|---|---|---|---|
| ☐ Abdomen | ☐ Face | ☐ Head | ☐ Pelvis | ☐ Other (explain) |
| ☐ Ankle ☐right ☐left | ☐ Eye ☐right ☐left | ☐ Hip ☐right ☐left | ☐ Tooth / mouth / jaw | |
| ☐ Arm ☐right ☐left | ☐ Finger (specify) | ☐ Knee ☐right ☐left | ☐ Shoulder ☐right ☐left | |
| ☐ Back | ☐ Foot ☐right ☐left | ☐ Leg ☐right ☐left | ☐ Toe (specify) | |
| ☐ Chest | ☐ Groin | ☐ Multiple | ☐ Scalp | |
| ☐ Ear ☐right ☐left | ☐ Hand ☐right ☐left | ☐ Neck | ☐ Wrist ☐right ☐left | ☐ No injury |

## PART III. NATURE OF INJURY OR ILLNESS

| | | | | | |
|---|---|---|---|---|---|
| ☐ Abrasion | ☐ Bite/Sting | ☐ Burn | ☐ Heart attack | ☐ Puncture | ☐ Dislocation |
| ☐ Allergic Reaction | ☐ Blister | ☐ Fall/Slip | ☐ Heat Stroke | ☐ Sprain/Strain | ☐ Concussion |
| ☐ Amputation | ☐ Bruise | ☐ Fracture | ☐ Laceration | ☐ Swelling | ☐ Other |

Describe in detail how the citizen or student was injured:

## PART IV. MEDICAL AND FIRST AID

| | | |
|---|---|---|
| Did the injured resume the activity after the injury?<br>Yes _____ No _____ | Was first aid administered?<br>Yes _____ No _____ | Administered by: |
| Describe first aid treatment: | | |
| | | |
| | | |
| Was rescue breathing administered?<br>Yes _____ No _____ | Was CPR administered?<br>Yes _____ No _____ | Was rescue squad called?<br>Yes _____ No _____ |
| Did injured refuse treatment?<br>Yes _____ No _____ | Injured transported to hospital?<br>Yes _____ No _____ | Name of medical facility: |

## PART V. WITNESSES (Use additional pages if necessary)

NAME:

_____

Last First Middle Initial

HOME ADDRESS:

_____

Street City State Zip Code

TELEPHONE NUMBERS: (Home) _____ (Work)_____

## PART VI. LOCATION OF INJURY

NAME OF BUILDING/SCHOOL:_____

ADDRESS:

_____

Street City State Zip Code

TELEPHONE NUMBER: _____

## PART VII. SIGNATURE

| | | |
|---|---|---|
| Printed Name of Employee Preparing Report<br>_____<br>Last First Middle Initial | Signature of Employee Preparing Report | |
| Department: | Telephone Number: | Date: |

NOTE: This form must be forwarded to the **RISK MANAGEMENT DEPARTMENT** within **ONE** business day of the incident. Email to RMCLAIMREPORTS@chesterfield.gov.