Form 135 Kurtz Bros., Clearfield, Pa.

REPORT BY TEACHER OF ACCIDENT OR INJURY TO PUPIL

(To be made in Triplicate for Nurse, Principal, and Administrator)
(Underline on Copies for proper delivery)

Child's Name .... Home Address ....

School.. Grade.................... Age.................... Sex .... Color....................

Time of Accident: A.M.......................... P.M.......................... Date ....

Place of Accident: School Building / Grounds.......................... Play Ground.......................... To or From School..........................

PART INJURED

Head....................	Arm	Leg ....
Scalp	Hand	Hip ....
Face....................	Shoulder....................	Knee....................
Eye....................	Elbow....................	Ankle....................
Ear....................	Wrist	Foot ....
Nose	Finger....................	Toes ....
Mouth	Chest....................	Back ....
Teeth....................	Abdomen....................	....
Other: (Specify)		

TYPE OF INJURY

Abrasion....................	Fracture....................
Amputation	Laceration ....
Asphyxiation....................	Poisoning ....
Bite....................	Puncture....................
Bruise	Scalds....................
Burn....................	Scratches ....
Concussion....................	Shock ....
Cut....................	Sprain ....
Dislocation....................	....
Other: (Specify)	

LOCATION OF ACCIDENT

Athletic Field....................	Locker....................
Auditorium....................	Shop....................
Cafeteria....................	Shower....................
Classroom....................	Pool....................
Corridor....................	School Grounds....................
Dressing Room....................	Stairs ....
Gymnasium....................	Street....................
Home Economics....................	Washroom ....
Laboratory....................	....
Other: (Specify)	
Describe Street Accident:	

DESCRIPTION OF ACCIDENT

How did it happen?

What was student doing?

Unsafe acts or conditions existing:

Was machinery or equipment involved? If so, specify.

Student hit by vehicle. Describe:

Degree of Injury:

Temporary Disability.................... Non-Disabling....................

Death.................... Permanent Impairment....................

Extent of Injury Unknown ....

Name of Teacher in Charge When Accident Occurred

....

Present at scene of accident: Yes.................... No....................

Was a parent notified? Yes.................... No....................

When:.................... How?....................

Name of parent notified:

....

By whom notified: ....

ACTION TAKEN

First aid treatment.................... By..

Sent to nurse.................... By..

Sent to physician.................... By..

Sent to.. Hospital (name)

Accepted Treatment: Yes .... No.................... Refused Treatment: Yes.................... Explain why on other side.

Witnesses: Name.. Address..

Name.. Address..

Number of days lost from school:.. (complete when child returns to school)

Signatures: Principal..

Teacher or Nurse..

☐ (Use reverse side to list recommendations for preventing other accidents of this type. Check ☐ at left.)

Pennsylvania Insurance Consortium for Schools

Phone 1-888-683-8311
Fax to: 888-683-8179

Injury Report

Employee Information Form (Faxed Report)

Company Name: ____________________

Employee SSN: ____________________ DOB: ____________________

Employee Name: ____________________

Home Address: ____________________

____

Home Phone: ____________________ Work Phone: ____________________

Job Title: ____________________Hours/Day:__________Days/Week __________Shift __________

Date of Employment: ______________ Status – Parttime/Fulltime, etc. ____________________

Family Physician: ____________________

Supervisor's Name: ____________________ Telephone: ____________________

WORK LOCATION/DEPARTMENT: ____________________

Location of Accident: ____________________

Date of Incident: ____________________ Time of Incident: ____________________

Please explain how and where injury happened: ____________________

____

____

____

Please describe your present symptoms: ____________________

____

____

Are you planning to seek medical treatment? ______ Yes _____ No ___Report for Record Only

Are you employed by another company? ______ Yes ______ No

Have you had previous work injuries? ______ Yes ______ No

Were there any witnesses to the incident? If so, please give names: ____________________

Employee Signature: ____________________Date: ______________

Scheduled Appointment

Physician:____________________Date/Time:____________________

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Pennsylvania Insurance Consortium for Schools

PLEASE FAX THIS FORM TO 888-683-8179 WITHIN TWO HOURS OF THIS VISIT.
FAX DICTATION AS SOON AS IT IS COMPLETED.

IF YOU HAVE ANY QUESTIONS, PLEASE CALL 1-888-683-8311
MAIL ALL BILLS TO CoordiNET 39 N. DUKE STREET, P. O. BOX 1728, LANCASTER, PA 17608-1728.

PHYSICIAN'S VISIT REPORT

Name______________________________ **DOB** / / **Employer**____________________ ___

Visit Date Time____________________ **Provider**____________________________________

Synopsis

Are your findings and diagnosis consistent with history and type of injury?	Yes	No	Unsure
Is work relationship established?	Yes	No	Unsure
Are there any current conditions that may affect patient's status/recovery?	Yes	No	Unsure

Current Diagnosis____________________________________ ____________________

Patient's Status Regarding This Injury:

___Fully Recovered
___Regular Duty
___Has Reached Maximum Medical Improvement
___May Return to Regular Work______________
___May Return to Restricted Work_______________
___Unable to Work Until______________________

THE EMPLOYEE IS CAPABLE OF PERFORMING: ___Sedentary ___ Light ___ Medium ___ Heavy

CIRCLE THE DEGREE OF LIMITATION WHERE APPLICABLE

Lifting	**None**	**10 lb**	**20 lb**	**50 lb**	**Other lb**
Carrying	None	10 lb	20 lb	50 lb	Other lb
Bending	**None**	**Occasional**	**Frequent**	**Constant**	
Squatting	**None**	**Occasional**	**Frequent**	**Constant**	
Kneeling	**None**	**Occasional**	**Frequent**	**Constant**	
Climbing	**No Fixed Stairs**		**No ladders**		
Reach	**Not with left**		**Not with right**		
Grasping	**Not with left**		**Not with right**		
Pushing/Pulling	**Not with left**		**Not with right**		

Comments:____

____

Studies/Treatment Ordered________________________ Facility/Date/Time________________

Next Appointment Date/Time____

Physician's Signature________________________ Date________________________________

I authorize physician to provide complete medical information to my employer and insurance carrier and to obtain records regarding this illness/injury.

Patient's Signature____________________________ Date___________________________