



TO BE COMPLETED BY STUDENT

Name _____

Banner #

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Date of Birth _____ Age _____

Local Address _____ Cell Phone _____

1. Date of Injury: _____ Date injury reported to Health Service _____

2. Time of Injury: _____ a.m. p.m.

3. Where did the injury on campus (be specific) (place/location):

4. Describe how injury occurred and body part(s) injured:

5. Was there something defective/damaged on campus that caused your injury? Yes No
If yes, please describe: _____

6. First aid treatment given prior to Student Health Service visit:

7. Witnesses: _____

8. Were you seen at a local hospital or physician's office? Yes No If yes, where? _____

STUDENT SIGNATURE _____ **DATE** _____

TO BE COMPLETED BY HEALTH PROVIDER

1. Medical treatment given: _____

DX _____

2. Referral to: X-rays ER Urgent Care Specialist None

3. Health & Safety Office notified at time of visit: Yes No

RN/MD SIGNATURE _____ **DATE** _____