STUDENT ACCIDENT/INJURY FORM

Student Name: _______ Student ID Number: _______

Date of Accident/Incident: ______

Location of Accident/Incident: ______

What was the student doing when accident/incident occurred: ______

Name of substance or object that caused accident/incident: ______

Describe in detail nature and extent of injury: ______

Was student treated at the scene?: □ Yes □ No

Was student admitted to the hospital?: □ Yes □ No

Transported to the hospital by ambulance or college personnel? □ Yes □ No

Hospital name: ______

Will student be able to return to class?: □ Yes □ No

Additional details: ______

Name(s) of witnesses to the accident/incident: ______

Student Signature: ___________________________ Date: ______________

LCC Employee Signature: ______________________ Date: ______________

* Copies of this form should be sent to each Vice President and the LCC Safety Coordinator.

4/19/18