

**HEBRON BAPTIST CHURCH
ACCIDENT/ILLNESS INVESTIGATION REPORT**

Name of Injured/Sick: _____ Parent if a Minor: _____

DOB of Injured/Sick _____ Age _____ Sex F / M Employee Yes No Dept. _____

Date of Incident: _____ Time of Incident: _____ AM / PM

NKDA ALLERGIES: _____

Present Medication Name/Dose: _____ None Unknown

PHM

- | | | | | | | | |
|--------------------------------|--|--|------------------------------------|----------------------------------|--|----------------------------------|-------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Unknown | <input type="checkbox"/> Angina | <input type="checkbox"/> Asthma | <input type="checkbox"/> CABG | <input type="checkbox"/> Cancer | <input type="checkbox"/> Cardiac | <input type="checkbox"/> COPD |
| <input type="checkbox"/> CVA | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Headaches | <input type="checkbox"/> HTN | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> MI | |
| <input type="checkbox"/> Psych | <input type="checkbox"/> Renal Failure | <input type="checkbox"/> Reflux | <input type="checkbox"/> Seizures | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Other | |

Tetanus N/A < 5 Yrs. > 5 Yrs. Unknown

Describe Fully the Nature of Injury/Illness: _____

Location of Accident/Illness (be specific): _____

List Any Witnesses: Name: _____ Phone: _____

Name: _____ Phone: _____

Actions Taken: Transported to Hospital - By Whom? _____ Where? _____

Medication Given – What type? _____

CPR Other _____

Injured or Parent Signature: _____

Address: _____ Phone: _____

Preparer's Signature: _____ Date of Report: _____

Preparer's Position/Title _____ Phone No. _____