IUSD HEALTH SERVICES

911 Report - CONFIDENTIAL

Stu #	Student's Name	DOB	M/F	School	Grade

Date of Incident: ____________________ Time of Incident: ____________________

Description of Incident (including staff involved and location): ____________________

Action Taken: ____________________

Condition of Student After Incident: ____________________

Student Released To: ____________________ Time: __________

Report Submitted By (Name/Title): ____________________

Date: ____________________ Time: __________

The following individuals were notified:

Principal/Designee	Date: __________	Time: __________
Parent	Date: __________	Time: __________
School Nurse	Date: __________	Time: __________
Child Care Provider	Date: __________	Time: __________
Paramedics	Date: __________	Time: __________
Other __________	Date: __________	Time: __________

FOR EACH 911 CALL, A REPORT MUST BE COMPLETED AND FAXED TO IUSD HEALTH SERVICES AT 949-936-7539.
Original is to be kept in Health Office 911 Report Folder until the end of the school year, and then transferred to student's health cum.

Reviewed 07-15-15