Policy: 5.62

Medical Emergencies

The Campus Police Office and/or the College Nurse shall be notified immediately when a medical emergency occurs on campus.

An individual evaluation will be made in all situations. A Report of Accident Form should be completed. In the event the individual (student or employee) is unconscious, Campus Police will automatically call the appropriate ambulance service.

"Making Life Better"
Kansas City Kansas Community College

7250 State Avenue Kansas City, KS 66112 913-334-1100 www.kckcc.edu

REPORT OF ACCIDENT

____Employee ____Student ____Other ***Please specify who accident happened to, check one***
Date of Accident: _____ Time: _____ a.m.___ p.m. ___ Location**: _____**
Occupation: _____ Date **report completed: _____**
Name: _____ Date of Birth: _____
Sex: _____
Home Address: _____City, State, & Zip:_____

Description of Accident: (How did the accident happen? What was injured party doing during the time of the accident? Name substance or object that directly caused injury. What corrective action was taken to prevent reoccurrence?)
_____
_____
_____

Part of Body Injured (Check all that apply):
Arms:
Elbows ___ Finger ___ Hand ____ Lower Arm ___ Shoulder ___Upper Arm ___Wrist ___

Legs:
Ankle __ Foot__ Knee__ Lower Leg __ Toe__ Upper Leg __

Head:
Ear __ Eye __ Face __ Mouth __ Neck __ Nose __ Scalp __ Teeth __

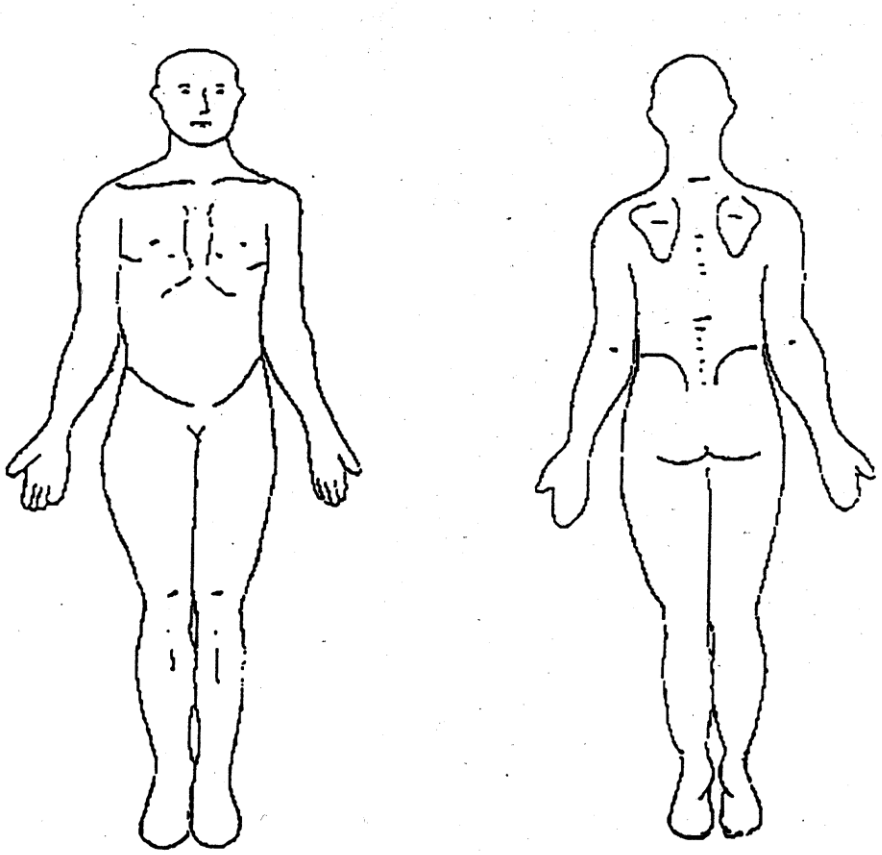
Trunk:
Abdomen__ Back __ Chest __ Collarbone __ Groin __ Pelvis __ Ribs __ Spine __
Other _____

Nature of Injury:
Abrasion __ Amputation __ Bite __ Bruise/ Contusion __ Burn/ Scald __ Concussion __
Cut/Laceration __ Dislocation __ Drowned __ Foreign Object__ Fracture __ Poison (solid or liquid) __

Poison (gas or vapor) __ Puncture wound __ Scratch__ Sprain/ Strain __ Shock (electrical) __ Suffocation __ Teeth Injury __ Other (Specify)
_____

First Aid Treatment given by (name): _____ On the scene? Yes___ No___
Sent to School Nurse by (name): _____ Date: _____
Name of Primary Physician: _____
Sent to the Hospital (Where): _____ Date: _____
Family notified: Yes __ No __ Witnesses to Accident (Names please.):
_____
(Attach witness reports)

_____
(Injured Party's Signature) Date
Report sent to Risk Management: Yes __ No __ Date: _____ (attach first responder's comments) (revised 5/09)



Nurse's or other first responders comments:

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