NCDSB

MEDICAL INCIDENT RECORD FORM

Student Name:	
Date of Birth:	

INCIDENT DETAILS	
Responding Staff Member(s):	
Date of Incident:	
Time of Incident:	
Length of Incident (minutes):	
Events before Incident (Please Describe)	
Description of Incident (Please Describe)	
Events After Incident (Please Describe)	
Any Previous Medical Incidents? ☐ Yes ☐ No If yes, please note dates:	
PARENT OR GUARDIAN CONTACT	
Name(s):	
Time Contacted:	
Notes:	
SIGNATURES	
Reporting Staff Member:	
Principal Signature:	
Date:	