INCIDENT REPORT FORM: DIOCESE OF OWENSBORO

◯ **Parish Event** ◯ **School Event** ◯ **Deanery Event** ◯ **Diocesan Event**

Date of the Incident _____ **Time of the Incident** _____

Name of the Person Harmed _____ Age _____

Address of the Person Harmed _____

_____

Parent/Guardian of Person Harmed _____

Phone Number (Day)_____ Phone Number (Evening) _____

Location of the Incident (Name of facility/ where in that facility) _____

_____

Person(s) Who Witnessed the Incident:

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

Describe how the incident happened. _____

_____

_____

_____

What were the apparent injuries? _____

_____

_____

How and by whom were the injuries treated at the scene? _____

_____

What additional medical assistance was sought? _____

_____

What (if any) hospital or medical facility was used? _____

_____

Was a parent/guardian contacted? Yes◯ No◯ By Whom: _____

Details: _____

(OVER)

◯ Parent/Guardian consented to medical treatment.

OR ◯ Parent/Guardian declined medical treatment.

Why?_____

What happened after the hospital/medical facility treatment (if applicable)? _____

_____

Present Condition of the Person Harmed _____

_____

Person Submitting Incident Report _____

Full Name Title

Date Report Completed _____

Mail or FAX a copy of this report (within two weeks maximum) to:

Chancellor/Administration
600 Locust Street
Owensboro, KY 42301
270-683-1545
FAX: 270-683-6883

Indicate on chart below the area(s) of injury.