D'YOUVILLE COLLEGE HEALTH CENTER ACCIDENT/ILLNESS REPORT

DATE FILED:_____ **DATE REC'D HC:**_____

STUDENT: ☐ **EMPLOYEE:** ☐ **VISITOR:** ☐ **SSN:**_____

NAME:_____ **AGE:**_____

ADDRESS:_____ **PHONE:**_____

_____

DESCRIBE ACCIDENT OR ILLNESS:

_____

_____

APPROXIMATE TIME OF ACCIDENT:_____

NAMES OF WITNESSES OF ACCIDENT:_____

IMMEDIATE TREATMENT:

_____

NO FURTHER TREATMENT REQUIRED:_____

TAKEN TO HOSPITAL:

NAME:_____ **DATE & TIME:**_____

ADDRESS:_____

SENT HOME:_____

ADVISED TO GO TO HEALTH CENTER:_____

HEALTH CENTER REMARKS:

_____

_____

This form should be forwarded to DYC Health Center (Marguerite Hall Room 103) immediately for insurance purposes and follow up.

_____
Supervisor

Use back of page for more detailed description if necessary.