# UNIVERSITY of INDIANAPOLIS

## MEDICAL EVENT FORM

*FORM SHOULD BE COMPLETED BY STUDENT OR FACULTY AND STAFF MEMBERS*

Name: ______________________________ Email: ______________________________

☐ Student ☐ Faculty ☐ Staff Phone: ______________________________

Location where acident occurred: ______________________________

Description of Medical Event: Please describe what happened. If an accident, list any specific acts by individuals or conditions that led to the accident. (include any tools, machinery or instrument involved)

______________________________

______________________________

______________________________

______________________________

______________________________

| Nature of Injury | | | Part of Body Injured | | |
|---|---|---|---|---|---|
| ___ Abrasion | ___ Cut | ___ Scratch | ___ Abdomen | ___ Face | ___ Leg |
| ___ Amputation | ___ Dislocation | ___ Shock | ___ Ankle | ___ Finger | ___ Mouth |
| ___ Asphyxiation | ___ Fracture | ___ Sprain | ___ Back | ___ Foot | ___ Nose |
| ___ Bite | ___ Laceration | ___ Splinter | ___ Chest | ___ Forearm | ___ Shoulder |
| ___ Bruise | ___ Poisoning | ___ Strain | ___ Ear | ___ Hand | ___ Teeth |
| ___ Burn | ___ Puncture | | ___ Elbow | ___ Head | ___ Wrist |
| ___ Concussion | ___ Repetitive Stress Injury | | ___ Eye | ___ Knee | ___ |
| Other specify) ______________________________ | | | Other (specify) ______________________________ | | |

Did police respond? Y N Police Dept. Name ____________________ Did EMS Respond? Y N

Did student go to the Health and Wellness Center for treatment? Y N

If no, name of treating facility? ______________________________

Will student need follow up treatment? Y N If yes, type of treatment: ____________________

Comments:

______________________________

______________________________

______________________________

______________________________

Signed: ______________________________ ____________________

Student/Faculty/Staff Member Date

**Email signed form to risk@uindy.edu**

Rev. January 2018