TCAPS
Traverse City Area Public Schools
412 Webster Street
Traverse City, MI 49686

PARENT/VOLUNTEER INJURY / EXPOSURE REPORT FORM

Parents/Volunteers seeking treatment for injuries and/or exposures must be seen by physicians at the **Munson Urgent Care or Occupational Health Clinic located at 550 Munson Avenue, Traverse City, MI 49686 (231-935-8590).** Life threatening emergencies or after hours incidents should report to the Emergency Room at Munson Medical Center at 1105 Sixth Street, Traverse City, MI 49684 (231-935-8500).

This form must be completed within 24 hours of the incident and returned to the Human Resources Office located at 412 Webster Street along with any medical documentation pertaining to the incident.

SECTION I: INJURED EMPLOYEE INFORMATION (To be completed by Parent/Volunteer)

Social Security # _____ Date of Injury _____ Time of Injury_____

Name _____
(Last) (First) (Middle)

Address_____
(Street (City) (State) (Zip)

Date of Birth_____ Sex: □ M □ F Home Phone_____

Occupation_____

Current Employer & Address_____

Number of dependents under 18_____ Marital Status: □ Single □ Married

If married, is spouse living with you? □ Yes □ No

Number of other family members at least 50% supported by Parent/Volunteer:_____

SECTION II: INJURY/EXPOSURE INFORMATION (To be completed by Parent/Volunteer)

Nature of injury/exposure_____
(i.e. cut, burn, blood, bodily fluids, chemicals)

Part of body injured/exposed_____
(i.e. right arm, left index finger, eye)

Explain how injury occurred_____

Location of incident (including building) _____

Witness(es)_____ Phone_____

Witness(es)_____ Phone_____

Sources of Exposure (if applicable)

Name_____
(Last) (First) (Middle)

Address_____
(Street) (City) (State) (Zip)

☐ Student ☐ Staff ☐ Other

SECTION III: FIRST AID (To be completed by Parent/Volunteer)

Describe first aid provided_____

_____

First aid provided by_____
(Name of person)

Have you or do you intend to seek medical treatment? ☐ Yes ☐ No

Where? ☐ Occupational Health ☐ Munson Emergency ☐ Other
(If "Other" provide name, address, phone and reason for selecting facility)

_____

I herby give permission to my medical provider to release information to my employer or insurance company.

Parent/Volunteer Signature_____ Date_____

Person completing if other than injured _____Date_____

SECTION IV: MEDICAL FOLLOW-UP (To be completed by health care provider)

Medical diagnosis_____

_____

Treatment/Recommendations_____

_____

Physician's Name_____ Phone_____
(please print)

Physician's Signature_____ Date_____

Follow-up appointment_____

SECTION V: REVIEW (Please sign and return to Human Resources within 24 hours)

Date TCAPS notified of injury _____

Unsafe act/s performed_____

Unsafe condition/s present _____

Action taken or planned to prevent recurrence_____

_____ _____ _____
Supervisor Signature Phone # Date