Nicholls State University
University Health Services

Incident Report

Name _____ Campus ID # _____
Address _____ F _____ M _____ D.O.B. _____
City _____ State _____ Zip _____ Phone _____
Job title _____ Department _____ Ext. _____

Date of accident/incident _____ Time of incident _____
Date reported _____ Time reported _____
Location of accident/incident _____

Witnesses

Name _____ Name _____
Address _____ Address _____
City, state, zip _____ City, state, zip _____
Telephone _____ Telephone _____

Description of accident/incident:

TPR _____ BP _____ Allergies _____

_____ Sore throat _____ Nasal Congestion _____ Chest Congestion _____ Coughing _____ Other
_____ Nausea _____ Vomiting _____ Diarrhea _____ Weakness
_____ Dizziness _____ Abdominal Pain _____ Stomach Cramps _____ Shortness of Breath

Describe injury/illness:

_____ First-aid rendered _____ To local medical doctor _____
_____ To hospital emergency room per _____ _____ To observe
_____ To recheck in _____

Date: _____ Reporting person: _____