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REPORT OF INJURY / ILLNESS

State Form 47134 (R2 / 1-20)
INDIANA LAW ENFORCEMENT ACADEMY
LAW ENFORCEMENT TRAINING BOARD

MEDICAL ALERT

INSTRUCTIONS:
1. *Please print legibly in black ink.*
2. *If the injured / ill student cannot sign this form, indicate "unable to sign" in lieu of the signature.*
3. *E-mail this forms to MedicalDocs@ilea.IN.gov.*

INJURED / ILL STUDENT INFORMATIOIN

Student's last name	Student's first name	Student's middle name	Suffix

Public Safety Identification (PSID) Number	ILEA student number

Name of department	Department telephone number ( )

Name of person to be notified concerning injury / illness	Relationship	Telephone number ( )

Signature of injured / ill student	Date *(month, day, year)*

INJURY / ILLNESS INFORMATION

Date of injury / illness *(month, day, year)*	Time of injury / illness *(0000 hours)*	Activity *(Check all that apply.)* ☐ Defensive tactics training ☐ Physical conditioning ☐ EVOC Training ☐ Firearms training ☐ During class time ☐ During off time

Location *(Check one.)*

☐ Media Center	☐ North Parking Lot	☐ Indoor Pistol Range	☐ Cinder Track	☐ EVOC Classroom	☐ Gymnasium 31A (old)
☐ Cafeteria	☐ South Parking Lot	☐ Outdoor Pistol Range	☐ Fitness Center	☐ EVOC Road Course	☐ Gymnasium 31B (new)
☐ Stairway	☐ Gun Locker Area	☐ Shotgun / Utility Range	☐ Fitness Trail	☐ EVOC Skill Pad	☐ Forensic Laboratory
☐ Cottage	☐ Dorm room # _____	☐ Pool / Training Tank	☐ Lake Area	☐ Classroom # _____	☐ Other _____

Comments

Signs of injury/ symptoms of illness – observable / reported / suspected *(Check all that apply.)*

☐ Unconsciousness	☐ Chest Pain	☐ Numbness / Tingling	☐ Pain / Tenderness	☐ Bleeding - Oozing	☐ Burn - Electrical / Heat
☐ Respiratory Distress	☐ Vomiting	☐ Discoloration / Swelling	☐ Neck / Back Injury	☐ Bleeding - Flowing	☐ Burn - Chemical
☐ Possible Heart Attack	☐ Diarrhea	☐ Nausea / Dizziness	☐ Leg / Foot Injury	☐ Bleeding - Spurting	☐ Burn - Abrasion
☐ Profuse Sweating	☐ Weakness	☐ Abdominal Injury	☐ Chest Injury	☐ Bleeding - Internal (?)	☐ Burn - Gunpowder
☐ Cold and Clammy	☐ Headache	☐ Arm / Hand Injury	☐ Eye Injury	☐ Other _____	☐ Other _____
☐ Cardiac Arrest	☐ Choking	☐ Head / Face Injury	☐ Joint Injury	☐ Other _____	☐ Other _____

Narrative description of injury / illness. If this is an injury report, describe how the injury occurred and list the names of any witnesses.

If related to a prior injury/ illness, describe how and when the original injury/ illness occurred.

Treatment provided at the academy

Blood pressure	Pulse	Time	Blood pressure	Pulse	Time	Examined / treated by:

TRANSPORTATION

Student transported to:
☐ Hendricks County Hospital ☐ Other: _____

Student transported by:
☐ Self ☐ Ambulance *(name / agency)*: _____ ☐ Other: _____

FOR STUDENTS WHO ELECT NOT TO SEEK HOSPITAL / PHYSICIAN TREATMENT

I do not consider my injury or illness to be serious enough to require examination or treatment by a physician at this time. If my condition does not permit me to participate fully in academic activities within forty-eight (48) hours, I understand that I must seek professional medical care.

Signature of student refusing medical care	Date medical care refused *(month, day, year)*

Report reviewed by:	Date of review *(month, day, year)*