INJURY PACKET 2017/18

1. **Incident Report**: fill out, have principal sign, send to Health Services office
2. **Mercy Authorization form** if going to a Mercy location: fill out front including drug and alcohol testing, send with employee to doctor
3. **St. Luke's Authorization form** if going to a St. Luke's location: fill out front including drug and alcohol testing, send with employee to doctor
4. **Post Accident Investigation form**: give to employee and tell them to get with their supervisor to fill out after they return from the doctor
5. **First Fill sheet**: give to employee and tell them to take this with them to the pharmacy if they are given a prescription from the doctor. If they are not given a prescription they can pitch it
6. **Workers Compensation Restricted Duty and Followup Appointment Guidelines sheet**: give to employee and tell them to get with their supervisor to read and sign after they return from the doctor

Risxfacs Login: 726594 (will never change)

Password: Elfelf72 (first E is capitalized, and this will change every month or so, I'll let you know.

Notes:

- Everything on this page is for employees **ONLY**.
- If it's a 911, or not 911 but still serious, do not worry about any paperwork for now
- When you do have an injury please call me just to let me know as soon as you can
- If the injury is questionable as to whether it's work related and it's not an emergency situation, please call me before you send them to the doctor
- If you have never called in (or done online) a claim to Risxfacs, call me and I will come to you and we'll go over it together
- Injuries to parents, visitors, etc. I only need the Incident Report
- If you have an injury but medical treatment is not necessary I only need the Incident Report
- My numbers – Jim Akers: Desk 314-415-8260
  Cell 314-393-4153

Parkway School District Incident Report

1. Name (Last) _____ (First) _____
2. Male _____ Female _____
3. Occupation _____ 4. Date of Injury _____/_____/_____ 5. Time of Injury _____ am/pm
6. Employee _____ Parent _____ Visitor _____ Student _____ (Grade____) Other (*specify*) _____
7. Parent Name _____ Home Phone (_____)_____-_____

8. NATURE OF INJURY: *Indicate (by* **Number**) *the injuries / symptoms incurred. (Record Numbers in boxes at left.)*

1 Abrasion / Scrape	5 Cuts / Laceration	9 No Pulse	13 Shortness of Breath	
2 Cuts / Bruise /Contusion	6 Dislocation (possible)	10 Not Breathing	14 Sprain / Strain / Tear	
3 Burns / Scald	7 Fracture / Broken (possible)	11 Pain / Tenderness	15 Swelling / Inflammation	
4 Concussion (possible)	8 Loss of Consciousness	12 Puncture	16 Other _____	

9. AREA AFFECTED: List affected area. *(Record Numbers in boxes at left.)*

Head		**Trunk**		**Extremities**		
1 Cheek	6 Mouth /Tongue / Lip	11 Stomach	16 Genitalia	20 Ankle	25 Hand	*Right and/or Left
2 Chin	7 Neck	12 Back	17 Internal	21 Arm	26 Knee	(circle)
3 Ear	8 Nose	13 Buttocks	18 Pelvis	22 Elbow	27 Leg	
4 Eye	9 Head	14 Chest / Ribs	19 Shoulder	23 Finger	28 Toe	
5 Forehead	10 Tooth / Teeth	15 Collarbone		24 Foot	29 Wrist	

10. CONTRIBUTING FACTOR: List contributing factor (by **Number**), which may have led to the above injury. *(Record Numbers in boxes at left.)*

1 Animal bite (dog, etc.)	5 Contact with fire (hot object/liquid)	9 Hit with thrown object	13 Weapon (gun, knife etc.)
2 Collision with object / person	6 Drug, alcohol etc.	10 Overexertion/Twisted	Specify _____
3 Compression / Pinch	7 Fall	11 Seizure disorder	14 Other _____
4 Contact with equipment (shop, home, etc)	8 Foreign body / object	12 Tripped/Slipped	15 Unknown

11. PERIOD: List time period (by **Number**) during which the injury occurred. *(Record Numbers in boxes at left.)*

1 After school	4 Athletic practice	7 Class time (not PE)	10 Lunch	13 PE Class
2 Assembly	5 Before school	8 Field trip	11 Lunch recess	14 Other _____
3 Athletic competition	6 Class change	9 Intramural competition	12 Recess	

12. SURFACE: List surface (by **Number**) where injury occurred. *(Record Numbers in boxes at left.)*

1 Blacktop	4 Dirt	7 Lawn / Grass	10 Synthetic	13 Tile (vinyl, rubber)
2 Carpet	5 Gravel	8 Mats	11 Wood (waxed)	14 Fiber
3 Concrete	6 Ice / Snow	9 Sand	12 Tile (ceramic)	15 Other _____

13. LOCATION: List location (by **Number**) where injury occurred. *(Record Numbers in boxes at left.)*

1 Athletic field	5 Corridor (excluding stairs)	9 Lunchroom / Kitchen	13 Sidewalk / Stairs / Ramp
2 Auditorium / Theater	6 Doorway	10 Playground / Playfield	14 Street / Driveway / Parking Area
3 Bus loading area	7 Gymnasium	11 Bus, School / Public	15 Restroom / Lavatory
4 Classroom	8 Lab (FACS, chem. etc.)	12 Shop (Indust. Arts, etc)	16 Other _____

14. ACTIVITY: List activity

1. Classroom activity	8. Walking
2. PE activity	9. Standing
3. Sports activity	10. Sitting
4. Climbing	11. Fighting
5. Fighting	12. Jumping
6. Moving equip/Setting up	13. Cleaning
7. Recess Activity	14. Cooking

Activity Description: _____

If playground injury, supervisor's names _____

15. EQUIPMENT: Was Equipment or apparatus involved in injury? Yes_____ No_____
IF YES, Specify Equipment _____
(a) Did equipment appear to be used appropriately? Yes_____ No_____
(b) Was there any apparent malfunction of equipment ? Yes_____ No_____

16. ACTION TAKEN: *Check and complete all that apply.*
First Aid administered (describe) _____
Emergency contact notified (who was notified & time of notification) _____
Returned to current activity Yes___ No___ (circle)
Sent / Taken home by and time _____
Called 911(Comments) _____
Referred for medical evaluation Yes No (circle)
Medical evaluation refused Yes No (circle)
Workman's Comp (Risxfacs) Notified Yes___ No___

17. DESCRIPTION: Describe specifically how injury happened. _____

Preparer's name	**Principal's signature**	**School / Building**	**Date of Report**

Mercy Corporate Health
mercycorporatehealth.net

Medical Authorization

(2)

For the corporate health centers, call to arrange an appointment if possible. Please complete below indicating your authorization:

Patient Name: _____ Appt Time: _____ Date: _____

Company: _____

Work Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Authorized by: _____ Date: _____
An officer or properly designated person *Signature* *Print*

By signing this authorization the above referenced company acknowledges and agrees that it is fiscally responsible for all incurred charges, whether work related or non-work related.

Work-related Injury/Illness	Specific Body Part: _____ *If this incident is deemed not work-related, the authorizing organization will be responsible for charges prior to written notification.*
Drug Screening *(check box)*	☐ **DOT** ☐ **NON-DOT** ☐ Pre-Placement ☐ Post-Accident ☐ Reasonable Suspicion ☐ Random ☐ Follow-up ☐ Witness/Observed ☐ Employee to pay
Alcohol Screening *(check box)*	☐ **DOT** ☐ **NON-DOT** ☐ Breath Alcohol ☐ Pre-Placement ☐ Post-Accident ☐ Reasonable Suspicion ☐ Random ☐ Follow-up ☐ Employer Pay ☐ Employee to Pay
Physical Exam *(check box)*	☐ Pre-Placement ☐ **DOT** ☐ Periodic/Annual ☐ Respiratory Clearance ☐ Employee to pay ☐ Other: _____
Immunization *(check box)*	☐ Hep A ☐ Hep B ☐ Flu ☐ TB ☐ Td ☐ Tdap ☐ Other _____ ☐ Employer to pay ☐ Employee to pay
Other Services *(check box)*	☐ PFT ☐ Audiometry ☐ Other _____

Patients under 18 years of age need written parental authorization for physicals, injury treatment and/or injections.

If your condition worsens, call the Treating Center. If your injury/illness requires emergency treatment, contact your employer for instruction and authorization to treat at an emergency room. All return visits should be scheduled at your Mercy treating locations.

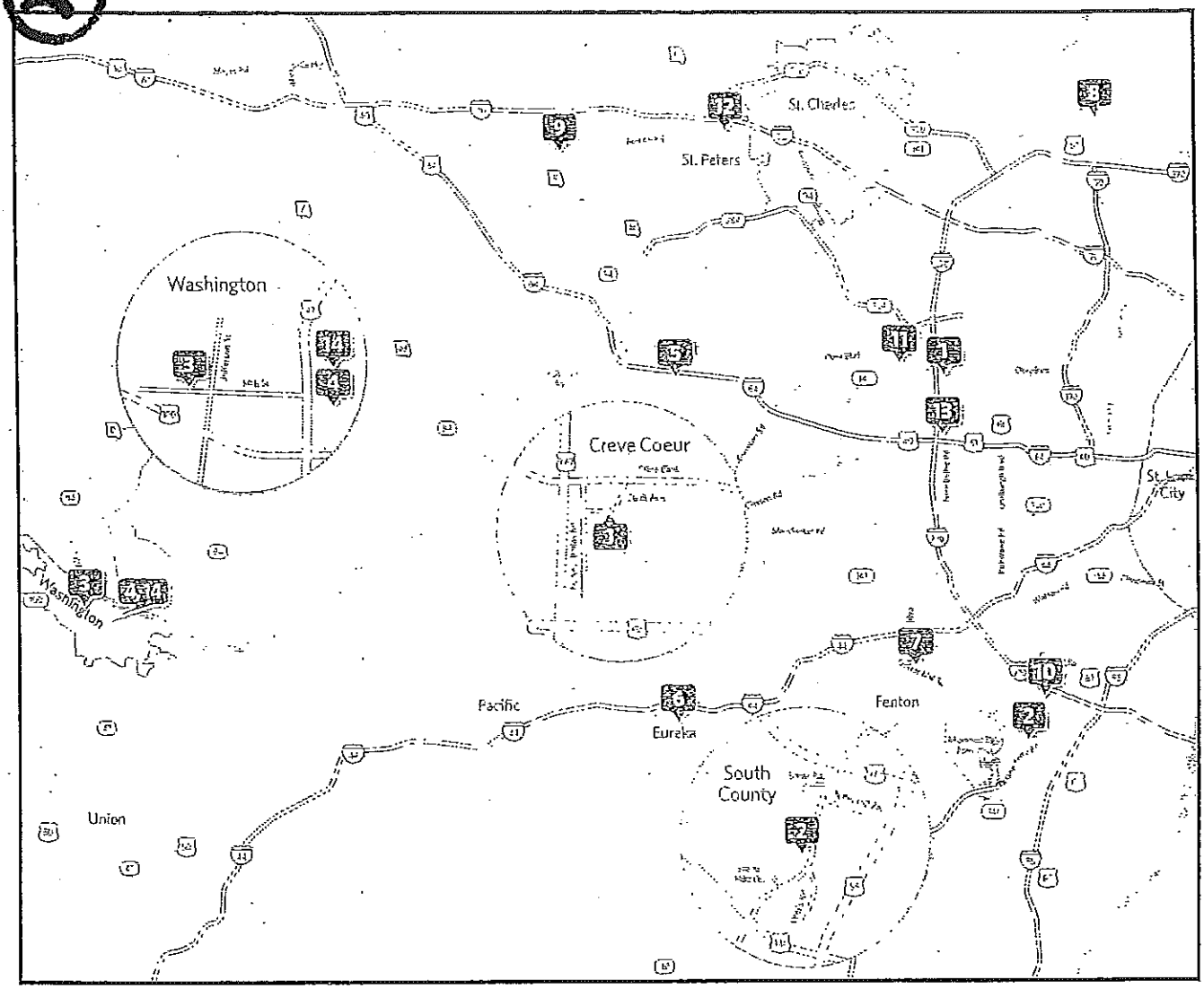
Mercy Corporate Health Creve Coeur | South County | Washington

Mercy Urgent Care Chesterfield | Eureka | Fenton | North County | O'Fallon | Old Tesson | Olive-Mason | St. Peters

Emergency Rooms Mercy Hospital St. Louis | Mercy Hospital Washington

See back of sheet for facility information and maps.

STL_4113 (5/18/16)



Mercy Corporate Health (Appointments are recommended)

1. **Creve Coeur** 11700 Studt Ave. | St. Louis, MO 63141
   Ph: 314-989-9199 | Fax: 314-989-9491 | Hours: 7 a.m. to 5 p.m., M-F
2. **South County** 13303 Tesson Ferry Rd. | Suite 50, Lower Level | St. Louis, MO 63128 | Ph: 314-729-9995 | Fax: 314-729-9994 | Hours: 7 a.m. to 5 p.m., M-F
3. **Washington**
   1351 Jefferson St. | Suite 208 | Washington, MO 63090
   Ph: 636-390-2600 | Fax: 636-390-4241 | Hours: 8 a.m. to 5 p.m., M-F
   Washington After Hours Only:
   4. **Mercy Convenient Care** 901 Patient's First Dr. | Washington, MO 63090
      Ph: 636-390-1777 | Fax: 636-390-1778 | 5 to 8 p.m., M-F | 8 a.m. to 8 p.m., Weekends

Mercy Urgent Care (Walk-Ins Only)

5. **Chesterfield Opening Fall 2016**
   17701 Edison Ave. | Chesterfield, MO 63005
   Ph: 314-251-8888 | Fax: 314-251-8889 | Hours: 8 a.m. to 8 p.m.
6. **Eureka** 20 The Legends Pkwy. | Suite 100 | Eureka, MO 63025
   Ph: 636-549 0100 | Fax: TBD | Hours: 8 a.m. to 8 p.m.
7. **Fenton Opening Summer 2016**
   1203 Smizer Mill Rd. | Fenton, MO 63026
   Ph: 636-717-1414 | Fax: 636-717-1420 | Hours: 8 a.m. to 8 p.m.
8. **North County** 637 Dunn Rd. | Suite 101 | Hazelwood, MO 63042
   Ph: 314-817-2000 | Fax: 314-817-1999 | Hours: 8 a.m. to 8 p.m., M-Sun.
9. **O'Fallon** 300 Winding Woods, Suite 100 | O'Fallon, MO 63366
   Ph: 636-379-4329 | Fax: 636-379-4328 | Hours: 8 a.m. to 8 p.m., M-Sun.
10. **Old Tesson New Injuries Only**
    12348 Old Tesson Rd. | St. Louis, MO 63128
    Ph: 314-272-2014 | Fax: 314-272-2170 | Hours: 8 a.m. to 8 p.m., M-Sun.
11. **Olive-Mason Opening Summer 2016**
    12680 Olive Blvd. | Suite 140 | St. Louis, MO 63141
    Ph: 314-251-8987 | Fax: TBD | Hours: 8 a.m. to 8 p.m.
12. **St. Peters** 107 Piper Hill Dr. | St. Peters, MO 63376
    Ph: 636-477-8757 | Fax: 314-219-6243 | Hours: 8 a.m. to 8 p.m., M-Sun.

Emergency Rooms

13. **Mercy Hospital St. Louis**
    615 S. New Ballas Rd. | St. Louis, MO 63141 | 314-251-6090
14. **Mercy Hospital Washington**
    901 E. Fifth St. | Washington, MO 63090 | 636-239-8011

Mercy

St. Luke's WORKPLACE HEALTH

Patient Name: _____ Date: _____

Employer Name: _____

Employer Address: _____

Employer Phone Number: _____ Fax: _____

Authorized By: _____
Printed Name Signature

Please Check Each Service Needed:

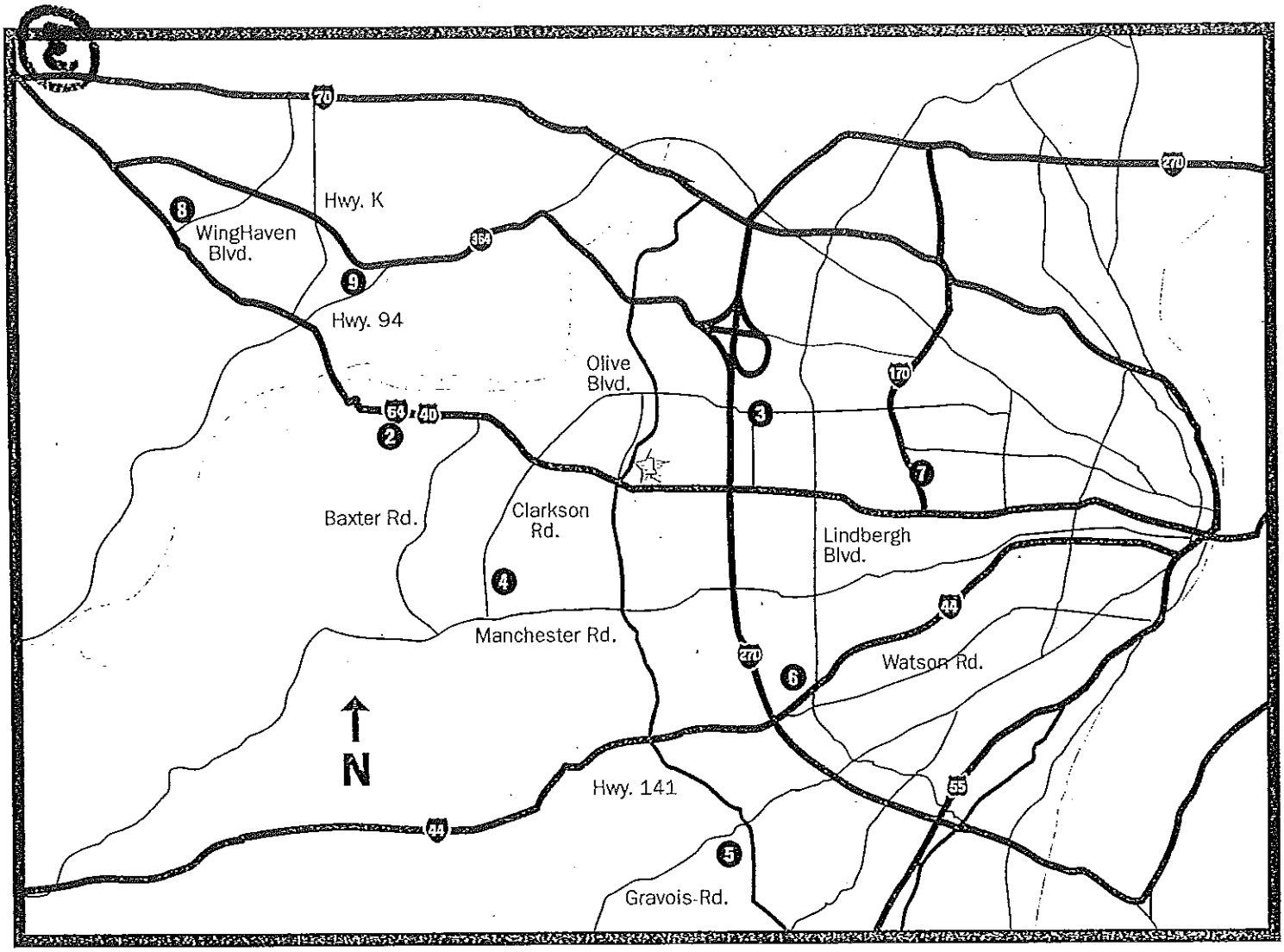
Work-Related Injury/Illness	☐ Specify Body Part: If this incident is deemed not work-related, the authorizing organization will be responsible for charges prior to written notification.
Drug Screening	○ DOT ○ NON-DOT ☐ Pre-placement ☐ Post Accident ☐ Reasonable Suspicion ☐ Follow-Up ☐ Random ☐ Witnessed/Observed ☐ Employee Paid
Alcohol Screening	○ DOT ○ NON-DOT ☐ Pre-placement ☐ Post Accident ☐ Reasonable Suspicion ☐ Follow-Up
Physical Exam	○ DOT ○ NON-DOT ☐ Pre-placement ☐ Periodic/Annual ☐ Respiratory Clearance ☐ Employee Paid ☐ Other: _____
Immunization	☐ Hepatitis A ☐ Hepatitis B ☐ Flu ☐ Td ☐ TDap ☐ Other ☐ Employee Paid
Other	☐ PFT ☐ Audiometry ☐ Other _____ ☐ TB

Patients under 18 years of age need written parental authorization for physicals, injury treatment and/or injections.

If your condition worsens, call the treating center. If your injury/illness requires emergency treatment, contact your employer for instruction and authorization to treat at an emergency room.
All return visits should be scheduled at your St. Luke's treating location.

St. Luke's Workplace Health Treatment Locations

St. Luke's Urgent Care Centers Open Daily from 8 a.m. – 8 p.m.	Chesterfield • Creve Coeur • Ellisville • Fenton Kirkwood • Ladue • O'Fallon • Weldon Spring
Workplace Health Corporate Clinic *Opening 7/18/16*	St. Luke's South Medical Office Building 224 S. Woods Mill Rd., Suite 360



St. Luke's Workplace Health Corporate Health Clinic
224 S. Woods Mill Rd.
South Medical Office Building Suite 260
Phone: 314-205-6677 | Fax: 314-205-6102

St. Luke's Hospital Emergency Department
232 S. Woods Mill Rd.
Phone: 314-205-6990 | Fax: 314-542-4734

2 **St. Luke's Urgent Care – Chesterfield**
17421 Chesterfield Airport Rd.
Phone: 636-685-7720 Fax: 636-685-7723

3 **St. Luke's Urgent Care – Creve Coeur**
11550 Olive Blvd.
Phone: 314-542-7690 Fax: 314-542-7698

4 **St. Luke's Urgent Care – Ellisville**
233 Clarkson Rd.
Phone: 636-256-8644 Fax: 636-230-9796

5 **St. Luke's Urgent Care – Fenton**
774 Gravois Bluffs Blvd.
Phone: 636-343-5223 Fax: 636-343-5345

6 **St. Luke's Urgent Care – Kirkwood**
455 South Kirkwood Rd.
Phone: 314-965-6871 Fax: 314-821-3245

7 **St. Luke's Urgent Care – Ladue**
8857 Ladue Rd.
Phone: 314-576-8189 Fax: 314-576-8162

8 **St. Luke's Urgent Care – O'Fallon**
5551 WingHaven Blvd.
Phone: 636-695-2500 Fax: 636-695-2515

9 **St. Luke's Urgent Care – Weldon Spring**
1051 Wolfrum Crossing
Phone: 636-300-0370 Fax: 636-300-8072

Call 314-205-6474 with questions.
stlukes-stl.com/workplace-health

St. Luke's HOSPITAL
Our Specialty is You

33159

PARKWAY SCHOOL DISTRICT

(4)

Post-Accident Investigation Form

Supervisor and employee complete this form within 24 hours of injury, forward to Safety Specialist when completed
If you have questions please call 5-8260

Employee name_____ Date of injury_____ Time_____
Exact location of accident (bldg., room, etc)_____
Describe in detail how the injury occurred (be specific)_____
_____
_____
_____
_____
Part(s) of the body injured_____
Was a regulation, safety procedure or policy violated (check one) Yes___ No___
If yes, please state regulation_____ Date employee trained on regulation_____
If witnesses, please state names_____
Is video available or are there photos of the site available (check one) Yes___ No___
If yes, please describe_____
Was a police report taken (check one) Yes___ No___ If yes, state jurisdiction & report number_____
Have you notified building manager or your supervisor to make sure surface/equipment are repaired (if necessary) to prevent future accidents? Yes___ No___
What can the employee do to prevent a reoccurrence of this accident_____
_____
_____
Has this been done? Yes___ No___ If not, state reason_____
What can the supervisor do to prevent a reoccurrence of this accident_____
_____
_____
Has this been done? Yee___ No___ If not, state reason_____
If applicable, date & time to follow-up with employee_____
Additional comments_____
_____
_____
_____

Injury type (check all that apply and proceed to that section(s) Lifting___ Slip/Fall___ Tool/Equipment___

Lifting (if applicable)
Was the item lifted/carried properly? Yes___ No___ If no, explain_____
Has employee been trained in proper lifting procedures? Yes___ No___ If yes, date trained_____
Approximate weight of item_____ Was this too heavy for employee to handle Yes___ No___
If yes, was mechanical assistance or co-employee assistance used? Yes___ No___
If no, explain why not_____
_____

Slip/Fall (if applicable)
What did employee slip on, fall from, or trip over_____
Please give details (be specific)_____
_____
_____
Walking surface damaged? Yes___ No___ If yes, did this contribute to accident? Yes___ No___
If yes, is Facilities aware? Yes___ No___
Did weather conditions contribute to this fall? Yes___ No___ If yes, describe_____

Slip Fall (cont)

Was employee carrying anything at time of fall? Yes___ No___ If yes, describe_____

If yes, did this contribute to the fall? Yes___ No___ If yes, describe how_____

Describe footwear employee was wearing at time of fall_____

Was signage posted of a hazard in the area? Yes___ No___ If yes, describe_____

Employee's address_____

(include city, state, zip)

Phone_____

SSN_____

Hire date_____

Salary_____

Date of birth_____

Employee's signature_____

Supervisor's signature_____

Date_____

OPTUM®

First Fill Information
Missouri United School Insurance Council

Dear Injured Worker,

Optum® has been selected by **Missouri United School Insurance Council** to assist you in obtaining prescription drugs related to your workers' compensation claim. This form enables you to fill prescriptions written by your authorized workers' compensation physician for medications related to your injury. Simply **fill in the form below** and present it at the pharmacy at the time your prescription is filled. This form should ensure that you will have no out-of-pocket expenses when you fill your first prescription.

For your convenience, Optum has an extensive network of retail pharmacies including major chain drug stores.

For pharmacy locations, you may call our toll-free number or visit our website at cypresscare.com and use the pharmacy locator in the quick links section of the home page.

If you have any questions, or would like to learn about our convenient home delivery service, please call our customer service number: 1-800-419-7191.

Estimado Trabajador(a) Lesionado(a),

Optum ha sido seleccionado por **Missouri United School Insurance Council** para asistirle en la obtención de medicamentos relacionados con su reclamo de compensación de trabajadores. Este formulario le permite completar las prescripciones escritas por el médico de sus empleados autorizados de compensación para los medicamentos relacionados con su lesión. Simplemente **llene el siguiente formulario** y preséntelo en la farmacia en el momento que su prescripción está lleno. Este formulario debe asegurarse de que usted no tendrá gastos de su propio bolsillo cuando surte su primera receta.

Para su comodidad, Optum cuenta con una extensa red de farmacias al por menor. De la red de farmacias Optum incluye las siguientes principales cadena de farmacias:

Para localidades de Farmacia adicional, también puede llamar a nuestro número gratuito o visite nuestro sitio web en cypresscare.com y usar el localizador de farmacias en la sección de enlaces rápidos de la página de inicio.

Si usted tiene alguna pregunta, o le gustaría aprender acerca de nuestro conveniente servicio al domicilio, llame a nuestro número gratuito de servicio al cliente: 1-800-419-7191.

First Fill Form: Complete and take to your pharmacy

Bin #: **010876** Group Number: MUSICFF

Member ID:		Last 4 digits of SSN + date of injury; No spaces (i.e. 9999050206)
Member Name:		Injured worker's first & last name
Employer Name:		
Date of Injury:		

Pharmacy Help Desk: 1-800-419-7191

PLEASE NOTE: This form allows you to fill your initial prescriptions with a cost maximum of $150 per prescription and no more than a 14-day supply per prescription. Once your claim has been reviewed, you will be sent a new card in the mail. If you do not receive the pharmacy card, please call us at **1-800-419-7191.**

Issuance of this letter does not constitute acceptance of your claim.

WORKER'S COMPENSATION

RESTRICTED DUTY and FOLLOW UP APPOINTMENT GUIDELINES

Due to your work-related injury, your authorized workers compensation medical physician may have placed you on temporary restricted duty. This means that you may or may not be able to perform your normal daily work functions due to the limitations the medical physician has prescribed.

The limitations may be such that you can perform your normal duties. However, if the restrictions are out of the realm of your normal job duties you will be assigned alternate duty that does accommodate your restrictions (you may be temporarily assigned to an alternate position and/or location for the duration of the restrictions; you may also be temporarily transferred to another shift to accommodate your restrictions; note: this does not apply to certified staff).

It is extremely important that you adhere to the following:

- You have a duty to help in your recovery, therefore you are expected to follow your medical physician's restrictions as stated and for the length of time stated
- In addition to adhering to your physician's restrictions during your workday at Parkway, you are expected to adhere to the restrictions during non-work hours (at home, other employment, etc.)
- All follow up appointments or therapy must be scheduled outside of your normal working hours or at a time agreeable with your Supervisor
- Overtime is not allowed while you are on restricted duty
- Sick time cannot be used to refuse restricted duty assignments
- If you are unclear about any portion of your restrictions, immediately contact the district's Safety Specialist for clarification
- If, while you are performing alternate duties you discover that you are performing outside of your medical physician's restrictions, immediately stop and contact your Supervisor AND the person who gave you the restricted duty assignment to see if the assignment can be altered to accommodate your restrictions. If the restrictions cannot be accommodated, contact your Supervisor and we will attempt to identify another light duty position that accommodates your restrictions
- After each medical appointment inform your Supervisor of any changes the medical physician has made to your restrictions
- If you have any questions throughout your entire treatment, contact your Supervisor immediately
- Failure to schedule and keep follow up appointments may cause your claim to be closed due to non-compliance
- Detailed information on Parkway's Workers Compensation policy and guidelines can be viewed on Parkway's intranet (GBGD.BP and GBGD.G) and in the Employee Handbook

Note: "The claimant agrees by signing this document that authorized treating medical professionals are permitted to discuss the claimant's medical condition and work restrictions with the Employer or their agents for the adjudication and processing of their worker's compensation case"

Employee signature_____

Date employee received_____

Supervisor signature_____

(Supervisor: after you and the employee have signed this form, give a copy to employee and send original to Jim Akers)

Rev. 3/16