

# CONFIDENTIAL SCHOOL ACCIDENT REPORT

CONFIDENTIAL-ATTORNEY/CLIENT WORK  
PRODUCT PRIVILEGE

This report is to be completed by school district employees. This form is a confidential, internal, document: its contents are not to be shared or copied for any persons who are not school district employees and/or their legal representatives. **IN CASE OF SERIOUS INJURIES A TELEPHONE REPORT IS TO BE MADE IMMEDIATELY.**

DATE OF REPORT	NOTE: The school employee either witnessing the accident or supervising at the time should complete and submit this form within 24 hours. Please type or print using ball-point pen.		
NAME OF SCHOOL DISTRICT 1	NAME OF SCHOOL 2		
ADDRESS OF SCHOOL (NUMBER, STREET, CITY AND ZIP CODE)			
NAME OF INJURED PERSON (LAST, FIRST, M.I.) 3	AGE	GRADE	TELEPHONE NUMBER OF INJURED PERSON ( )
IS INJURED PERSON A MINOR <input type="checkbox"/> NO <input type="checkbox"/> YES ▶	NAME OF PARENT OR LEGAL GUARDIAN		
ADDRESS OF PERSON INJURED (NUMBER, STREET, APARTMENT NUMBER, CITY, STATE AND ZIP CODE) 4			
WHERE DID ACCIDENT OCCUR 5	DATE (MONTH/DAY/YEAR)	TIME <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	
DESCRIBE HOW ACCIDENT OCCURRED (USE FACTS ONLY; EXCLUDE OPINIONS AND/OR ASSUMPTIONS) 6			
FIRST AND LAST NAME OF PERSON IN CHARGE AT TIME OF ACCIDENT 7		TITLE OF PERSON (TEACHER, VOLUNTEER, ETC.)	WAS HE PRESENT AT THE TIME <input type="checkbox"/> YES <input type="checkbox"/> NO INJURED VIOLATED SCHOOL RULE <input type="checkbox"/> YES <input type="checkbox"/> NO
8	NAME OF WITNESS(ES)	ADDRESS	TELEPHONE NO. ( )  ( ) STATUS (Student, Volunteer, etc.)
9 APPARENT NATURE OF INJURY (PLEASE CHECK)		10 INJURED PART OF BODY (PLEASE CHECK)	
<input type="checkbox"/> Abrasion <input type="checkbox"/> Fracture <input type="checkbox"/> Strain/Sprain <input type="checkbox"/> Contusion <input type="checkbox"/> Cut <input type="checkbox"/> Dislocation <input type="checkbox"/> Internal <input type="checkbox"/> Concussion <input type="checkbox"/> Other (explain)		<input type="checkbox"/> Head <input type="checkbox"/> Finger <input type="checkbox"/> Arm <input type="checkbox"/> Abdomen <input type="checkbox"/> Neck <input type="checkbox"/> Eye <input type="checkbox"/> Leg <input type="checkbox"/> Hand <input type="checkbox"/> Back <input type="checkbox"/> Chest <input type="checkbox"/> Face <input type="checkbox"/> Foot <input type="checkbox"/> Other (explain)	
FIRST AID PROCEDURES USED 11		NAME OF PERSON WHO ADMINISTERED FIRST AID	
12 DISPOSITION OF INJURED AFTER ACCIDENT OR CLASS <input type="checkbox"/> Home <input type="checkbox"/> Doctor <input type="checkbox"/> Hospital <input type="checkbox"/> Classroom		13 WHO WAS NOTIFIED	RELATIONSHIP TO INJURED
14 IF INJURED PUPIL LEFT SCHOOL TO WHOM RELEASED		15 NAME AND ATTITUDE OF ANYONE CONTACTING SCHOOL	
16 STUDENT ACCIDENT BENEFITS AVAILABLE <input type="checkbox"/> NO <input type="checkbox"/> YES    NAME OF COMPANY		REMARKS 17	
REMARKS CONTINUED			

For your protection California law requires the following to appear on this form. "It is unlawful to: (a) present or cause to be presented any false or fraudulent claim for payment of a loss under a contract of insurance; (b) prepare, make or subscribe any writing with intent to present or use the same, or allow it to be presented or used in support of such claim. Every person who violates any provision of this section is punishable by imprisonment in the State Prison not exceeding 3 years or by fine not exceeding \$1,000 or by both."

NAME OF PERSON COMPLETING REPORT 18	STATUS	TELEPHONE NUMBER OF PERSON ( )
ADDRESS OF PERSON (NUMBER, STREET, CITY, STATE AND ZIP CODE)		PERSON WAS AN EYE WITNESS <input type="checkbox"/> YES <input type="checkbox"/> NO
SIGNATURE OF PERSON APPROVING REPORT	DATE SIGNED	

SUBMIT TO:  
 HAZELRIGG RISK MANAGEMENT SERVICES  
 14275 PIPELINE AVENUE  
 CHINO, CA 91710  
 ATTN: NANCY WAYNE  
 FAX: (909) 627-8402



**Alliance of Schools for Cooperative Insurance Programs**

12750 Center Court Drive, Suite 205, Cerritos, CA 90703 Phone (562)403-4640 Fax (562)403-4644