

# 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.**

**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.

DATE OF REPORT		1		NAME OF SCHOOL		2	
NAME OF SCHOOL DISTRICT							
ADDRESS OF SCHOOL (NUMBER, STREET, CITY AND ZIP CODE)							
NAME OF INJURED PERSON (LAST, FIRST, M.I.)				AGE	GRADE	TELEPHONE NUMBER OF INJURED PERSON	
3						( )	
IS INJURED PERSON A MINOR		NAME OF PARENT OR LEGAL GUARDIAN					
<input type="checkbox"/> NO <input type="checkbox"/> YES							
ADDRESS OF PERSON INJURED (NUMBER, STREET, APARTMENT NUMBER, CITY, STATE AND ZIP CODE)							
4							
WHERE DID ACCIDENT OCCUR				DATE (MONTH/DAY/YEAR)		TIME	
5						<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			TITLE OF PERSON (TEACHER, VOLUNTEER, ETC.)			WAS HE PRESENT AT THE TIME	INJURED VIOLATED SCHOOL RULE
7						<input type="checkbox"/> YES <input type="checkbox"/> NO	<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"/> Head <input type="checkbox"/> Finger <input type="checkbox"/> Arm <input type="checkbox"/> Abdomen			
<input type="checkbox"/> Contusion <input type="checkbox"/> Cut <input type="checkbox"/> Dislocation				<input type="checkbox"/> Neck <input type="checkbox"/> Eye <input type="checkbox"/> Leg <input type="checkbox"/> Hand			
<input type="checkbox"/> Internal <input type="checkbox"/> Concussion				<input type="checkbox"/> Back <input type="checkbox"/> Chest <input type="checkbox"/> Face <input type="checkbox"/> Foot			
Other <input type="checkbox"/> (explain)				Other <input type="checkbox"/> (explain)			
11 FIRST AID PROCEDURES USED						NAME OF PERSON WHO ADMINISTERED FIRST AID	
12 DISPOSITION OF INJURED AFTER ACCIDENT OR CLASS						13 WHO WAS NOTIFIED	
<input type="checkbox"/> Home <input type="checkbox"/> Doctor <input type="checkbox"/> Hospital							
14 IF INJURED PUPIL LEFT SCHOOL TO WHOM RELEASED				15 NAME AND ATTITUDE OF ANYONE CONTACTING SCHOOL			
16 STUDENT ACCIDENT BENEFITS AVAILABLE				REMARKS			
<input type="checkbox"/> NO <input type="checkbox"/> YES				17			
NAME OF COMPANY				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."

18 NAME OF PERSON COMPLETING REPORT		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  
CARL WARREN AND COMPANY  
P.O BOX 25180  
SANTA ANA, CA 92799-5180**



**Alliance of Schools for Cooperative Insurance Programs**  
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