



# Confidential School Accident Report

## Alliance of Schools for Cooperative Insurance Programs

16550 Bloomfield Avenue • Cerritos, CA 90703 • PH: (562) 404-8029 FAX: (562) 404-8038 • www.ascip.org

**CONFIDENTIAL-ATTORNEY/CLIENT WORK PRODUCT PRIVILEGE**

This report is to be completed by district employees. This form is a confidential, internal, document: its contents are not to be shared or copied for any persons who are not 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 district 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.

<b>1</b> NAME OF SCHOOL DISTRICT/CCD		<b>2</b> NAME OF SITE	
ADDRESS OF SITE (NUMBER, STREET, CITY AND ZIP CODE)			
<b>3</b> NAME OF INJURED PERSON (LAST, FIRST, M.I.)		AGE	GRADE
		TELEPHONE NUMBER OF INJURED PERSON (    )	
IS INJURED PERSON A MINOR <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES	NAME OF PARENT OR LEGAL GUARDIAN		
ADDRESS OF PERSON INJURED (NUMBER, STREET, APARTMENT NUMBER, CITY, STATE AND ZIP CODE)			
<b>4</b> WHERE DID ACCIDENT OCCUR		DATE (MONTH/DAY/YEAR)	TIME <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.
<b>5</b> DESCRIBE HOW ACCIDENT OCCURRED (USE FACTS ONLY; EXCLUDE OPINIONS AND/OR ASSUMPTIONS)			
<b>6</b>			
<b>7</b> FIRST AND LAST NAME OF PERSON IN CHARGE AT TIME OF ACCIDENT		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
<b>8</b> NAME OF WITNESS(ES)	ADDRESS	TELEPHONE NO.	STATUS (Student, Volunteer, etc.)
		(    )	
		(    )	
<b>9</b> APPARENT NATURE OF INJURY (PLEASE CHECK)		<b>10</b> 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) _____	
<b>11</b> FIRST AID PROCEDURES USED		NAME OF PERSON WHO ADMINISTERED FIRST AID	
<b>12</b> DISPOSITION OF INJURED AFTER ACCIDENT OR CLASS <input type="checkbox"/> Home <input type="checkbox"/> Doctor <input type="checkbox"/> Hospital <input type="checkbox"/> Classroom		<b>13</b> WHO WAS NOTIFIED	RELATIONSHIP TO INJURED
<b>14</b> IF INJURED PUPIL LEFT SITE TO WHOM RELEASED		<b>15</b> NAME AND ATTITUDE OF ANYONE CONTACTING SCHOOL/CCD	
<b>16</b> STUDENT ACCIDENT BENEFITS AVAILABLE <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>17</b> REMARKS		
NAME OF COMPANY			

**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."**

<b>18</b> 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: CORVEL**  
**P.O. BOX 277550, SACRAMENTO, CA 95827**  
**ATTN: PAT VITALE – FAX: (866) 430-4203**