Confidential School Incident 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 representative.
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. This form is interactive.

NAME OF SCHOOL DISTRICT/CCD	NAME OF SITE		
ADDRESS OF SITE (NUMBER, STREET, CITY AND ZIP CODE)			
NAME OF INJURED PERSON (LAST, FIRST, M.I.)	**AGE**	**GRADE**	**TELEPHONE NUMBER OF INJURED PERSON**
			( )
IS INJURED PERSON A MINOR ☐ NO ☐ YES →	**NAME OF PARENT OR LEGAL GUARDIAN**		
ADDRESS OF PERSON INJURED (NUMBER, STREET, APARTMENT NUMBER, CITY, STATE AND ZIP CODE)			
WHERE DID ACCIDENT OCCUR	**DATE (MONTH/DAY/YEAR)**	**TIME**	☐ A.M. ☐ P.M.
DESCRIBE HOW ACCIDENT OCCURRED (USE FACTS ONLY; EXCLUDE OPINIONS AND/OR ASSUMPTIONS)			
FIRST AND LAST NAME OF PERSON IN CHARGE AT TIME OF ACCIDENT	**TITLE OF PERSON (TEACHER, VOLUNTEER, ETC.)**	**WAS HE/SHE PRESENT AT THE TIME** ☐ NO ☐ YES	**INJURED VIOLATED SCHOOL RULE** ☐ NO ☐ YES

NAME OF WITNESS(ES)	ADDRESS	TELEPHONE NUMBER	STATUS (Student, Volunteer, etc.)
		( )	
		( )	

APPARENT NATURE OF INJURY (PLEASE CHECK)			INJURED PART OF BODY (PLEASE CHECK)			
☐ Abrasion	☐ Fracture	☐ Strain/Sprain	☐ Head	☐ Finger	☐ Arm	☐ Abdomen
☐ Contusion	☐ Cut	☐ Dislocation	☐ Neck	☐ Eye	☐ Leg	☐ Hand
☐ Internal	☐ Concussion		☐ Back	☐ Chest	☐ Face	☐ Foot
☐ Other _____			☐ Other _____			

FIRST AID PROCEDURES USED	NAME OF PERSON WHO ADMINISTERED FIRST AID

DISPOSITION OF INJURED AFTER ACCIDENT OR CLASS (PLEASE CHECK)	WHO WAS NOTIFIED	RELATIONSHIP TO INJURED
☐ Home ☐ Doctor ☐ Hospital ☐ Classroom		
IF INJURED PUPIL LEFT SITE, TO WHOM RELEASED	**NAME AND ATTITUDE OF ANYONE CONTACTING SCHOOL/CCD**	
STUDENT ACCIDENT BENEFITS AVAILABLE ☐ NO ☐ YES	**NAME OF COMPANY**	
REMARKS		

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	STATUS	TELEPHONE NUMBER OF PERSON
		( )
ADDRESS OF PERSON (NUMBER, STREET, APARTMENT NUMBER, CITY, STATE AND ZIP CODE)		
SIGNATURE OF PERSON APPROVING REPORT	**DATE SIGNED**	**PERSON WAS AN EYE WITNESS**

RESET FORM

SUBMIT FORM TO CORVEL ATTN: JOAN WEEKS – FAX: (562) 404-4515
12621 166TH STREET, CERRITOS, CA 90703

REVISED: 7/11