Confidential School Accident Report

Alliance of Schools for Cooperative Insurance Programs

12750 Center Court Drive, Suite 205 • Cerritos, CA 90703 • PH: (562) 403-4640 FAX: (562) 403-4644 • www.ascip.org

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 of 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

RESET FORM

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.

1 NAME OF SCHOOL DISTRICT: GILROY UNIFIED SCHOOL DISTRICT		2 NAME OF SCHOOL		
ADDRESS OF SCHOOL (NUMBER, STREET, CITY AND ZIP CODE)				
3 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			
4 ADDRESS OF PERSON INJURED (NUMBER, STREET, APARTMENT NUMBER, CITY, STATE AND ZIP CODE)				
5 WHERE DID ACCIDENT OCCUR	DATE (MONTH/DAY/YEAR)	TIME ☐ A.M. ☐ P.M.		
6 DESCRIBE HOW ACCIDENT OCCURRED (USE FACTS ONLY; EXCLUDE OPINIONS AND/OR ASSUMPTIONS)				
7 FIRST AND LAST NAME OF PERSON IN CHARGE AT TIME OF ACCIDENT	TITLE OF PERSON (TEACHER, VOLUNTEER, ETC.)	WAS HE PRESENT AT THE TIME ☐ YES ☐ NO	INJURED VIOLATED SCHOOL RULE ☐ YES ☐ NO	

8 NAME OF WITNESS(ES)	ADDRESS	TELEPHONE NO.	STATUS (Student, Volunteer, etc.)
		( )	
		( )	

9 APPARENT NATURE OF INJURY (PLEASE CHECK)
☐ Abrasion ☐ Fracture ☐ Strain/Sprain
☐ Contusion ☐ Cut ☐ Dislocation
☐ Internal ☐ Concussion
☐ Other (explain) _____

10 INJURED PART OF BODY (PLEASE CHECK)
☐ Head ☐ Finger ☐ Arm ☐ Abdomen
☐ Neck ☐ Eye ☐ Leg ☐ Hand
☐ Back ☐ Chest ☐ Face ☐ Foot
☐ Other (explain) _____

11 FIRST AID PROCEDURES USED	NAME OF PERSON WHO ADMINISTERED FIRST AID	
12 DISPOSITION OF INJURED AFTER ACCIDENT OR CLASS ☐ Home ☐ Doctor ☐ Hospital ☐ 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 ☐ YES ☐ NO	17 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."

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 ☐ YES ☐ NO
SIGNATURE OF PERSON APPROVING REPORT	DATE SIGNED		

Gilroy Unified School District
Business Services Department
(fax) 408-846-7561