



Confidential School Accident Report

Alliance of Schools for Cooperative Insurance Programs

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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

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.

NAME OF SCHOOL DISTRICT 1 GILROY UNIFIED SCHOOL DISTRICT		NAME OF SCHOOL 2	
ADDRESS OF SCHOOL (NUMBER, STREET, CITY AND ZIP CODE)			
NAME OF INJURED PERSON (LAST, FIRST, M.I.) 3		AGE	GRADE
IS INJURED PERSON A MINOR <input type="checkbox"/> NO <input type="checkbox"/> YES		TELEPHONE NUMBER OF INJURED PERSON ()	
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.)	INJURED VIOLATED SCHOOL RULE <input type="checkbox"/> YES <input type="checkbox"/> NO
NAME OF WITNESS(ES) 8		ADDRESS	STATUS (Student, Volunteer, etc.)
APPARENT NATURE OF INJURY (PLEASE CHECK) 9		INJURED PART OF BODY (PLEASE CHECK) 10	
<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	
DISPOSITION OF INJURED AFTER ACCIDENT OR CLASS 12 <input type="checkbox"/> Home <input type="checkbox"/> Doctor <input type="checkbox"/> Hospital <input type="checkbox"/> Classroom		WHO WAS NOTIFIED 13	RELATIONSHIP TO INJURED
IF INJURED PUPIL LEFT SCHOOL TO WHOM RELEASED 14		NAME AND ATTITUDE OF ANYONE CONTACTING SCHOOL 15	
STUDENT ACCIDENT BENEFITS AVAILABLE 16 <input type="checkbox"/> YES <input type="checkbox"/> NO		REMARKS 17	
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."

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	

Gilroy Unified School District
Business Services Department
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