

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 representative
**IN CASE OF SERIOUS INJURIES A TELEPHONE
REPORT IS TO BE MADE IMMEDIATELY**

DATE OF REPORT	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 ballpoint pen.		
NAME OF SCHOOL DISTRICT 1. William S. Hart Union High School District		NAME OF SCHOOL Wm. S. Hart ROP	
ADDRESS OF SCHOOL (NUMBER, STREET, CITY AND ZIP CODE) 2.			
NAME OF INJURED PERSON (LAST, FIRST, M.I.) 3.		AGE	GRADE
TELEPHONE NUMBER OF INJURED PERSON			
IS INJURED PERSON A MINOR <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> α		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.) Teacher	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			
8. NAME OF WITNESS(ES)	ADDRESS	AREA CODE	TELEPHONE NO.
STATUS <small>(Student, Volunteer, etc.)</small>			
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"/> Contusion <input type="checkbox"/> Cut <input type="checkbox"/> Dislocation <input type="checkbox"/> Internal <input type="checkbox"/> Concussion Other <input type="checkbox"/> (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 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 <input type="checkbox"/> Home <input type="checkbox"/> Doctor <input type="checkbox"/> Hospital		13. WHO WAS NOTIFIED	
RELATIONSHIP TO INJURED		14. IF INJURED PUPIL LEFT SCHOOL TO WHOM RELEASED	
15. NAME AND ATTITUDE OF ANYONE CONTRACTING SCHOOL		16. STUDENT ACCIDENT BENEFITS AVAILABLE	
<input type="checkbox"/> NO <input type="checkbox"/> YES <small>NAME OF COMPANY</small>		17. REMARKS	
REMARKS CONTINUED			
<p>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."</p>			
18. NAME OF PERSON COMPLETING REPORT		STATUS	
ADDRESS OF PERSON (NUMBER, STREET, CITY STATE AND ZIP CODE)		TELEPHONE NUMBER OF PERSON	
SIGNATURE OF PERSON APPROVING REPORT		DATE SIGNED	
PERSON WAS AN EYE WITNESS <input type="checkbox"/> YES <input type="checkbox"/> NO			

SUBMIT TO: Nancy Wayne
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