



Confidential School Incident Report

Alliance of Schools for Cooperative Insurance Programs

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 incident or supervising at the time should complete and submit this form within 24 hours. This is an interactive form.					
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 INCIDENT OCCUR			DATE (MONTH/DAY/YEAR)		TIME A.M. P.M.		
DESCRIBE HOW INCIDENT OCCURRED (USE FACTS ONLY; EXCLUDE OPINIONS AND/OR ASSUMPTIONS)							
FIRST AND LAST NAME OF PERSON IN CHARGE AT TIME OF INCIDENT		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 INCIDENT OR CLASS (PLEASE CHECK) Home Doctor Hospital Classroom				WHO WAS NOTIFIED		RELATIONSHIP TO INJURED	
IF INJURED PUPIL LEFT SITE, TO WHOM RELEASED				NAME AND ATTITUDE OF ANYONE CONTACTING SCHOOL/CCD			
STUDENT INCIDENT 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

**SUBMIT FORM TO ASCIP ATTN: CLAIMS MANAGER –
 FAX: (562) 404-4515 - 16550 BLOOMFIELD AVENUE,
 CERRITOS, CA 90703**