

School Incident Report Form For Insurance Purposes

1 GENERAL

Name of School Division: _____

Name and Address of School: _____

Date of Incident M/D/Y: _____ Time _____ : _____ a.m. / _____ p.m. Telephone # () - _____

Description of How Incident Occurred: _____

Witnesses: (1) Name: _____ Teacher/Instructor/Other: _____ Witness Activity at Time: _____ (2) Name: _____ Teacher/Instructor/Other: _____ Witness Activity at Time: _____	Location of Incident: L01 <input type="checkbox"/> Basement L02 <input type="checkbox"/> Cafeteria/Lunchroom L03 <input type="checkbox"/> Classroom L04 <input type="checkbox"/> Shops/Lab/Kitchen L05 <input type="checkbox"/> Doors/Entrance Areas L06 <input type="checkbox"/> Dormitories L07 <input type="checkbox"/> Gymnasium/Auditorium L08 <input type="checkbox"/> Hallways/Lockers L09 <input type="checkbox"/> Library/Office/Lounge/ Study Room L10 <input type="checkbox"/> Park/Grounds L11 <input type="checkbox"/> Parking Lot L12 <input type="checkbox"/> Playing Fields L13 <input type="checkbox"/> Playground Equipment L14 <input type="checkbox"/> Pool L15 <input type="checkbox"/> Rink L16 <input type="checkbox"/> Sidewalks/Roads Off Facility Property L17 <input type="checkbox"/> Stairs with Building L18 <input type="checkbox"/> Stairs/Sidewalks within Grounds L19 <input type="checkbox"/> Washrooms/Changing Rooms/Showers L20 <input type="checkbox"/> Other – (please explain)
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2 COMPLETE THE APPROPRIATE SECTION

Name of Person Involved: _____ Age: _____ M/F: _____

Address: _____ Postal Code: _____ Grade/Year/Night School: _____
(Schools Only)

Student/Visitor/Other: (explain) _____ Division/Program: _____

Parent/Guardian/Emergency Contact: _____ Notified? Yes No How? _____

Telephone #: () - _____

Parent/Guardian/Emergency Contact Instructions: _____

Emergency Treatment: Yes No What? _____ By Whom? _____

Advised to Seek Medical Treatment: Yes No Where? _____ Hospitalized Overnight? Yes No

How Transported? _____

Nature of Injury/Damage: N01 <input type="checkbox"/> Bruise/Abrasion/Swelling N02 <input type="checkbox"/> Burn N03 <input type="checkbox"/> Concussion (suspected) N04 <input type="checkbox"/> Crushed N05 <input type="checkbox"/> Dental Damage N06 <input type="checkbox"/> Dislocation N07 <input type="checkbox"/> Fatality/Death N08 <input type="checkbox"/> Fracture N09 <input type="checkbox"/> Imbedded Object N10 <input type="checkbox"/> No Information N11 <input type="checkbox"/> Nosebleed N12 <input type="checkbox"/> Open Wound / Laceration N13 <input type="checkbox"/> Sprain/Strain (suspected) N14 <input type="checkbox"/> Winded N15 <input type="checkbox"/> Property DMB / Other Party N16 <input type="checkbox"/> Bites/Stings N17 <input type="checkbox"/> Other – (please explain)	Body Area: B01 <input type="checkbox"/> Arms/Shoulder/Elbow B02 <input type="checkbox"/> Chest/Abdomen/Pelvis B03 <input type="checkbox"/> Eyes B04 <input type="checkbox"/> Face B05 <input type="checkbox"/> Feet/Toes B06 <input type="checkbox"/> Fingers/Hands/Wrists B07 <input type="checkbox"/> Head/Forehead B08 <input type="checkbox"/> Legs/Knees/Ankles B09 <input type="checkbox"/> Multiple Areas B10 <input type="checkbox"/> Neck B11 <input type="checkbox"/> No Information B12 <input type="checkbox"/> Spine/Back B13 <input type="checkbox"/> Teeth/Mouth B14 <input type="checkbox"/> Other – (please explain)
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Cause of Injury or Damage: C01 <input type="checkbox"/> Assault-No Weapon C02 <input type="checkbox"/> Assault with Weapon C03 <input type="checkbox"/> Choking/Suffocation C04 <input type="checkbox"/> Drowning C05 <input type="checkbox"/> Exposure to Flame/ Electricity/Hot or Caustic Substance C06 <input type="checkbox"/> Fall at Same Height C07 <input type="checkbox"/> Fall from Different Height C08 <input type="checkbox"/> Fatigue/Over Exertion C09 <input type="checkbox"/> Foreign Body C10 <input type="checkbox"/> Horseplay C11 <input type="checkbox"/> Maintenance Activity C12 <input type="checkbox"/> Motor Vehicle Accident C13 <input type="checkbox"/> Poison/Allergic Reaction C14 <input type="checkbox"/> School Bus Accident C15 <input type="checkbox"/> Sports Injury C16 <input type="checkbox"/> Struck Against Person C17 <input type="checkbox"/> Struck/Crushed By/ Against Object C18 <input type="checkbox"/> Other – (please explain)	Activity at Time of Incident: A01 <input type="checkbox"/> Academic Classroom A02 <input type="checkbox"/> Between Classes A03 <input type="checkbox"/> Extra-Curricular (i.e. Club) A04 <input type="checkbox"/> Out-Of-Class Field Trip A05 <input type="checkbox"/> Recess/Pre-Or Post Class/Noon Hour A06 <input type="checkbox"/> Sports Event A07 <input type="checkbox"/> Sported Related Class A08 <input type="checkbox"/> Travel to or from Facility A09 <input type="checkbox"/> Unorganized Sports A10 <input type="checkbox"/> Work Placement A11 <input type="checkbox"/> Maintenance Activity A12 <input type="checkbox"/> Other – (please explain)
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3 COMPLETE THE APPROPRIATE SECTION

Property Involved (describe property involved and extent of loss and/or damage): _____

SECTION B Fire Department Attended? <input type="checkbox"/> Yes <input type="checkbox"/> No Report Number: _____ Were Police Notified? <input type="checkbox"/> Yes <input type="checkbox"/> No Branch/Detachment: _____ Case Number: _____ Date (M/D/Y): _____ Time: _____ : _____ a.m. / p.m. Were There Visible Signs of Forced Entry? <input type="checkbox"/> Yes <input type="checkbox"/> No What? (explain) _____	Cause of Loss/Damage: C01 <input type="checkbox"/> Burglary/Forcible Entry C02 <input type="checkbox"/> Collapse C03 <input type="checkbox"/> Dishonesty/Infidelity C04 <input type="checkbox"/> Explosion C05 <input type="checkbox"/> Falling Object C06 <input type="checkbox"/> Fire/Lightning C07 <input type="checkbox"/> Glass Breakage C08 <input type="checkbox"/> Impact By Vehicle/Aircraft C09 <input type="checkbox"/> Riot C10 <input type="checkbox"/> Robbery C11 <input type="checkbox"/> Smoke C12 <input type="checkbox"/> Theft C13 <input type="checkbox"/> Transportation C14 <input type="checkbox"/> Vandalism/ Malicious Acts C15 <input type="checkbox"/> Water Escape/ Rupture/Freezing C16 <input type="checkbox"/> Windstorm/Hail C17 <input type="checkbox"/> Other – (please explain)
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Name of Person Completing Report: _____ (Please Print or Type) _____ (Signature)

Name of Administrator: _____ (Please Print or Type) _____ (Signature)

Date: _____

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