Accident Report

This form is to be completed by the appropriate employee(s) as soon as possible after an accident occurs.
Please Print or Type.
NOTE: This form may also be filed electronically from the KSBA web site (www.ksba.org)

District Name _____ School Name _____

Principal's Name _____ School Phone _____

Date of Accident: _____ Time: ____ ☐ AM ☐ PM Supervising Employee _____

Claimant's Name _____ _____ _____
Last Name *First Name* *Middle Initial*

Claimant's Address _____ _____ _____
City *State* *ZIP Code*

Claimant's SS # _____ Home Phone Number (___) _____

Claimant's Age _____ Date of Birth _____ Sex _____ Grade _____

Parent's Name (if student) _____ Work Phone Number (___) _____

Nature of Injury	
☐ Scratch	☐ Concussion
☐ Fracture	☐ Head Injury
☐ Bruise	☐ Sprain/Strain
☐ Burn	☐ Cut/Puncture
☐ Dislocation	☐ Bite
☐ Other _____	

Place of Accident	
☐ Classroom	☐ Gymnasium
☐ Hallway	☐ Parking Lot
☐ Bathroom	☐ Sidewalk
☐ Cafeteria	☐ Stairs
☐ Playground	☐ Athletic Field
☐ Other _____	

Body Part Injured		
☐ Ankle	☐ Foot	☐ Leg
☐ Arm	☐ Face	☐ Nose
☐ Back	☐ Finger	☐ Teeth
☐ Neck	☐ Hand	☐ Wrist
☐ Eye	☐ Knee	☐ Shoulder
☐ Other _____		

Describe accident and injury in detail: (Attach additional description as necessary). _____

_____

Were efforts made to contact the parent/guardian about the accident? ☐ Yes ☐ No

Was first aid administered? ☐ Yes ☐ No By whom? _____

Was the student ☐ Sent home ☐ Sent to physician ☐ Sent to hospital

Is student covered by Student Accident Insurance? ☐ Yes ☐ No If *yes*, please list Company Name, address and phone number _____

If medical or hospital treatment was required, please complete the following information. (Attach a copy of medical bills, if available.)

Name and address of doctor or hospital _____

Witnesses (Name, Address & Phone) _____

_____

_____ _____
Signature/Name of Person Completing the Report *Date*

Forward completed form to your General Liability Insurance carrier. If your carrier is the Kentucky School Boards Insurance Trust, mail the completed form to Liability Claims Service, 260 Democrat Drive, Frankfort, KY 40601.

RELATED PROCEDURE:

09.14 AP.1

Review/Revised: 07.15.01