## ACCIDENT REPORT

This accident report is to be completed for ALL incidents requiring a doctor visit whether or not the parent files an insurance claim through the school. File this report in the student's permanent school record.

Name of School:				
Person Completing Report:		Phone:		
Date of Accident:	Time:	AM	PM	
Location of accident:				
Student's name:			Age:	
Address:		Phone:		
Parent's Name:				
Parent's Employer:				
Parent's Medical Insurance Co.:				
Doctor treating this incident:				
Name:	Phone:			
Address:				
Was anyone else involved in the acciden	t: YesNo			
Name of that person:		Phone:		
Name and relationship to student of pers	son who picked up s	tudent:		
Nature or description of the injury (use	reverse if necessary)	:		
Were Paramedics called?If "y	es", attach copy of p	oaramedic re	eporting documen	
Witnesses to the accident:				
Name:				
Name:	Phone:			