LOS ALAMITOS UNIFIED SCHOOL DISTRICT
10293 BLOOMFIELD STREET
LOS ALAMITOS, CA 90720
PH: (562) 799-4700, Ext. 80449
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Submit To:

NANCY C. NIEN
ASSISTANT SUPERINTENDENT
BUSINESS SERVICES

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 representatives.

IN CASE OF SERIOUS INJURIES A TELEPHONE REPORT IS TO BE MADE IMMEDIATELY (NUMBER LISTED ABOVE)

CONFIDENTIAL SCHOOL ACCIDENT 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 ball point pen.

DATE OF REPORT	SITE OF ACCIDENT/INCIDENT
ADDRESS/LOCATION OF ACCIDENT/INCIDENT	

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/LEGAL GUARDIAN
ADDRESS OF PERSON INJURED	

WHERE DID ACCIDENT OCCUR	DATE OF ACCIDENT	APPROXIMATE TIME OF ACCIDENT ☐AM ☐PM

DESCRIBE HOW ACCIDENT OCCURRED (USE FACTS ONLY; EXCLUDE OPINIONS AND/OR ASSUMPTIONS)

FIRST AND LAST NAME OF PERSON IN CHARGE AT TIME OF ACCIDENT	TITLE OF PERSON (TEACHER, VOLUNTEER, ETC.)	PRESENT AT TIME OF ACCIDENT? ☐ NO ☐ YES	INJURED VIOLATED SCHOOL RULE? ☐ NO ☐ YES

NAME OF WITNESS(ES)	ADDRESS	TELEPHONE NO.	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 (Explain) _____			☐ Other (Explain) _____			

FIRST AID PROCEDURES USED	NAME OF PERSON WHO ADMINISTERED FIRST AID

DISPOSITION OF INJURED AFTER ACCIDENT ☐ Home ☐ Doctor ☐ Hospital ☐ Class	WHO WAS NOTIFIED	RELATIONSHIP TO INJURED

IF INJURED PUPIL LEFT SCHOOL TO WHOM RELEASED	NAME OF ANYONE CONTACTING SCHOOL

STUDENT ACCIDENT BENEFITS AVAILABLE? YES ☐ NO ☐	REMARKS
NAME OF COMPANY (IF YES)	

NAME OF PERSON COMPLETING REPORT	TITLE	TELEPHONE NO.	EYE WITNESS? ☐ NO ☐ YES

SIGNATURE – ASSISTANT SUPERINTENDENT, BUSINESS SERVICES	DATE