



Office of Risk Management

Liability Claims Reporting Procedures

Report claims **IMMEDIATELY** to:

Risk Management Department

tbell@mylUSD.org

Phone: (310) 886-1600 x8053

Date stamp all claims when received.

All potential claims for liability coverage must be referred to Risk Management, **no exceptions.**

- Injuries, property damage, automobile from third party
- Student Incident Reports
- Lawsuits
- Cease and Desist Orders

LIABILITY COVERAGES

Liability (Third Party)

Comprehensive General Liability, Auto Liability, Errors and Omissions

Accident Med-Pay

This coverage is geared primarily for those cases where the district may have some liability for the injury; especially if it is a serious injury or the injured party has no other insurance. This program is intended to be a contingent program; therefore, parents of students are still encouraged to purchase a voluntary program or separate coverage for football and other sports.

Professional Liability

Incidental Malpractice (School Nurses)



Tiffany Bell
Director of Risk Management

SUBMIT TO:
KEENAN & ASSOCIATES
P.O. BOX 4328
TORRANCE, CA 90510
TELEPHONE: (310)212-3344 (800)654-8102
FAX: (310) 212-6847

**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.

CONFIDENTIAL SCHOOL ACCIDENT REPORT

IN CASE OF SERIOUS INJURIES A TELEPHONE
REPORT IS TO BE MADE IMMEDIATELY

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		NAME OF SCHOOL	
ADDRESS OF SCHOOL (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 ACCIDENT OCCUR		DATE (MONTH/DAY/YEAR)	TIME ☐ 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.)	WAS HE/SHE PRESENT AT THE TIME? ☐ 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) ☐ Abrasion ☐ Fracture ☐ Strain/Sprain ☐ Contusion ☐ Cut ☐ Dislocation ☐ Internal ☐ Concussion ☐ Other (Explain) _____		INJURED PART OF BODY (PLEASE CHECK) ☐ Head ☐ Finger ☐ Arm ☐ Abdomen ☐ Neck ☐ Eye ☐ Leg ☐ Hand ☐ Back ☐ Chest ☐ Face ☐ Foot ☐ 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 AND ATTITUDE OF ANYONE CONTACTING SCHOOL	
STUDENT ACCIDENT BENEFITS AVAILABLE ☐ NO ☐ YES		REMARKS	
NAME OF COMPANY			
REMARKS CONTINUED			
NAME OF PERSON COMPLETING REPORT		STATUS	TELEPHONE NUMBER OF PERSON ()
ADDRESS OF PERSON (NUMBER, STREET, CITY, STATE AND ZIP CODE)			WAS PERSON AN EYE WITNESS? ☐ NO ☐ YES
SIGNATURE OF PERSON APPROVING REPORT		DATE SIGNED	