



# Confidential School Incident Report

## Ontario-Montclair School District

950 W D Street Ontario, CA 91762

**CONFIDENTIAL-ATTORNEY/CLIENT WORK PRODUCT PRIVILEGE**

This report is to be completed by district employees. This form is a confidential, internal, document: its contents are not to be shared or copied for any persons who are not district employees and/or their legal representatives. **IN CASE OF SERIOUS INJURIES A TELEPHONE REPORT IS TO BE MADE IMMEDIATELY.**

DATE OF REPORT		NOTE: The district employee either witnessing the incident or supervising at the time should <b>complete and submit this form within 24 hours</b> . This is an interactive form.			
NAME OF SCHOOL DISTRICT/ COLLEGE DISTRICT			NAME OF SITE		
ADDRESS OF SITE (NUMBER, STREET, CITY, STATE AND ZIP CODE)					
NAME OF INJURED PERSON (LAST, FIRST, M.I.)			AGE	GRADE	TELEPHONE NUMBER OF INJURED PERSON
IS INJURED PERSON A MINOR <input type="checkbox"/> NO <input type="checkbox"/> YES		NAME OF PARENT OR LEGAL GUARDIAN			
ADDRESS OF PERSON INJURED (NUMBER, STREET, APARTMENT NUMBER, CITY, STATE AND ZIP CODE)					
WHERE DID INCIDENT OCCUR (ON/OFF SITE, WHERE SPECIFICALLY)			DATE OF INCIDENT (MONTH/DAY/YEAR)		TIME <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.
DESCRIBE HOW INCIDENT OCCURRED (USE FACTS ONLY; EXCLUDE OPINIONS AND/OR ASSUMPTIONS)					
FULL NAME OF PERSON IN CHARGE AT TIME OF INCIDENT		TITLE OF PERSON (TEACHER, VOLUNTEER, ETC.)		WAS HE/SHE PRESENT AT THE TIME? <input type="checkbox"/> NO <input type="checkbox"/> YES	INJURED VIOLATED SCHOOL RULE? <input type="checkbox"/> NO <input type="checkbox"/> YES
NAME OF WITNESS(ES)		ADDRESS		TELEPHONE NUMBER	TITLE
APPARENT NATURE OF INJURY (PLEASE CHECK) <input type="checkbox"/> Abrasion <input type="checkbox"/> Fracture <input type="checkbox"/> Strain/Sprain <input type="checkbox"/> Contusion <input type="checkbox"/> Cut <input type="checkbox"/> Dislocation <input type="checkbox"/> Internal <input type="checkbox"/> Concussion <input type="checkbox"/> Other			INJURED PART OF BODY (PLEASE CHECK) <input type="checkbox"/> Head <input type="checkbox"/> Finger <input type="checkbox"/> Arm <input type="checkbox"/> Abdomen <input type="checkbox"/> Neck <input type="checkbox"/> Eye <input type="checkbox"/> Leg <input type="checkbox"/> Hand <input type="checkbox"/> Back <input type="checkbox"/> Chest <input type="checkbox"/> Face <input type="checkbox"/> Foot <input type="checkbox"/> Other		
FIRST AID PROCEDURES USED			NAME OF PERSON WHO ADMINISTERED FIRST AID		
DISPOSITION OF INJURED AFTER INCIDENT <input type="checkbox"/> Home <input type="checkbox"/> Doctor <input type="checkbox"/> Hospital <input type="checkbox"/> Classroom		WHO WAS NOTIFIED		RELATIONSHIP TO INJURED	FORM GIVEN?*** <input type="checkbox"/> YES <input type="checkbox"/> NO
IF INJURED PUPIL LEFT SITE TO WHOM RELEASED			NAME AND ATTITUDE OF ANYONE CONTACTING SCHOOL/ DISTRICT		
IS STUDENT INCIDENT BENEFITS AVAILABLE? <input type="checkbox"/> NO <input type="checkbox"/> YES			NAME OF COMPANY		
REMARKS					

For your protection, California law requires the following to appear on this form. "It is unlawful to: (a) present or cause to be presented any false or fraudulent claim for payment of a loss under a contract of insurance; (b) prepare, make or subscribe any writing with intent to present or use the same, or allow it to be presented or used in support of such claim. Every person who violates any provision of this section is punishable by imprisonment in the State Prison not exceeding 3 years or by fine not exceeding \$1,000 or by both."

NAME OF PERSON COMPLETING REPORT		TITLE	TELEPHONE
ADDRESS OF PERSON (NUMBER, STREET, APARTMENT NUMBER, CITY, STATE AND ZIP CODE)			
SIGNATURE OF PERSON APPROVING REPORT		DATE SIGNED	PERSON WAS AN EYE WITNESS

**SUBMIT FORM TO RISK MANAGEMENT:**

EMAIL: [Risk.Mgmt@omsd.net](mailto:Risk.Mgmt@omsd.net) or

FAX: (909) 459-2565

# School Incident Report

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Your student was injured during school. If you have any additional questions feel free to call the school's office.

NAME OF SCHOOL DISTRICT/ COLLEGE DISTRICT	NAME OF SITE	
NAME OF INJURED PERSON (LAST, FIRST, MI)	DATE OF INCIDENT (MONTH/DAY/YEAR)	
DESCRIBE HOW INCIDENT OCCURRED (USE FACTS ONLY; EXCLUDE OPINIONS AND/OR ASSUMPTIONS)		
<b>APPARENT NATURE OF INJURY (PLEASE CHECK)</b> <input type="checkbox"/> Abrasion <input type="checkbox"/> Fracture <input type="checkbox"/> Strain/Sprain <input type="checkbox"/> Contusion <input type="checkbox"/> Cut <input type="checkbox"/> Dislocation <input type="checkbox"/> Internal <input type="checkbox"/> Concussion <input type="checkbox"/> Other	<b>INJURED PART OF BODY (PLEASE CHECK)</b> <input type="checkbox"/> Head <input type="checkbox"/> Finger <input type="checkbox"/> Arm <input type="checkbox"/> Abdomen <input type="checkbox"/> Neck <input type="checkbox"/> Eye <input type="checkbox"/> Leg <input type="checkbox"/> Hand <input type="checkbox"/> Back <input type="checkbox"/> Chest <input type="checkbox"/> Face <input type="checkbox"/> Foot <input type="checkbox"/> Other	
FIRST AID PROCEDURES USED		
NAME OF PARENT OR LEGAL GUARDIAN	SIGNATURE OF PARENT OR LEGAL GUARDIAN	DATE