

Ventura County Schools Self-Funding Authority
Report of Personal Accident
CONFIDENTIAL – ATTORNEY – CLIENT PRIVILEGE

TO BE COMPLETED IMMEDIATELY		<input type="checkbox"/> STUDENT	<input type="checkbox"/> VENDOR
THE SCHOOL EMPLOYEE WHO EITHER WITNESSES THE INJURY OR IS SUPERVISING AT THE TIME OF INJURY SHOULD COMPLETE THIS FORM, IF POSSIBLE. THE REPORT SHOULD BE SUBMITTED IMMEDIATELY TO THE APPROPRIATE SCHOOL DISTRICT OFFICE. SHOULD OTHER PERTINENT FACTS DEVELOP, NOTIFY THE SCHOOL DISTRICT OFFICE BY MEANS OF A SUPPLEMENTAL REPORT.		<input type="checkbox"/> PARENT	<input type="checkbox"/> OTHER
SCHOOL DISTRICT		SCHOOL	
SCHOOL ADDRESS		PHONE NO.	
INJURED PARTY'S NAME		SEX	AGE
HOME ADDRESS		DAYTIME PHONE	HOME PHONE
WHERE DID ACCIDENT OCCUR?		DATE	TIME
HOW DID ACCIDENT OCCUR?			
STATEMENT OF INJURED PARTY			
EMPLOYEE IN CHARGE OF INJURED STUDENT AT TIME OF ACCIDENT:		WAS EMPLOYEE PRESENT AT THE TIME OF ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
WAS ANY SCHOOL RULE VIOLATED? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF SO, EXPLAIN	
NAME		WITNESSES PRESENT AT TIME OF ACCIDENT ADDRESS	
NATURE OF INJURY		DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
FIRST AID APPLIED? <input type="checkbox"/> YES <input type="checkbox"/> NO		HAVE PARENTS CONTACTED SCHOOL? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DISPOSITION OF INJURED PARTY (RETURN TO CLASS, HOME DOCTOR HOSPITAL)		NAME OF PERSON NOTIFIED	
LIST NAME OF STUDENT'S SCHOOL ACCIDENT INSURANCE COVERAGE		BY WHOM NOTIFIED?	DATE
		TIME	
COMMENTS			
REPORT SUBMITTED BY		POSITION	PHONE
		DATE	