

CALAVERAS UNIFIED SCHOOL DISTRICT
P.O. Box 788
San Andreas, CA 95249
INCIDENT REPORT

E 5141.1

Student _____
Non Student _____
Other _____

CALAVERAS UNIFIED SCHOOL DISTRICT

SCHOOL DISTRICT		SCHOOL	
SCHOOL ADDRESS		AREA	PHONE NUMBER
NAME OF INJURED		BIRTHDATE	GRADE
HOME ADDRESS		AREA	PHONE NUMBER
WHERE DID ACCIDENT OCCUR?		DATE	TIME
HOW DID ACCIDENT OCCUR?			
EMPLOYEE IN CHARGE OF INJURED PERSON AT TIME OF ACCIDENT NAME:			WAS EMPLOYEE PRESENT?
WAS ANY SCHOOL RULE VIOLATED?	IF SO, EXPLAIN		
WITNESSES PRESENT AT TIME OF ACCIDENT			
NAME	ADDRESS	AREA	PHONE NUMBER
NATURE OF INJURY			
WAS FIRST AID APPLIED?	BY WHOM?		
DISPOSITION OF INJURED PERSON (RETURN TO CLASS, HOME, DOCTOR, HOSPITAL)			
DOES INJURED PERSON HAVE SCHOOL ACCIDENT INSURANCE COVERAGE		NAME OF INSURANCE COMPANY	
HAVE PARENTS CONTACTED SCHOOL?		WHAT WAS THEIR ATTITUDE?	
COMMENTS			
REPORT SUBMITTED BY		POSITION	DATE

Send Original and one copy to the district office.