

# INCIDENT REPORT

WASHINGTON SCHOOLS • Risk Management Pool

PO BOX 88700, TUKWILA, WA 98138-2700 • 800-488-7569 • FAX 800-831-0175

Please use this form to ~ REPORT ALL CLAIMS OR POTENTIAL CLAIMS

DO NOT use this form to ~ REPORT EMPLOYEE (on-the-job) INJURIES

*Report to the Pool Immediately and Forward Supplemental Information Under Separate Cover, If Necessary*

## GENERAL INFORMATION

DISTRICT **BLAINE SCHOOL DISTRICT 503**

DATE COMPLETED

NAME OF CONTACT PERSON **PATT VAN WANSEELE**

PHONE # **360-332-5881**

## INCIDENT INFORMATION

INJURY  VEHICLE  PROPERTY DAMAGE/LOSS (non-vehicle)

DATE OF INCIDENT

TIME AM / PM

LOCATION  CLASS  PLAYGROUND  GYM  LABORATORY  SHOP  OFF-PREMISES  OTHER, SPECIFY \_\_\_\_\_

SCHOOL NAME

DESCRIPTION OF INCIDENT OR ACCIDENT

WITNESS(ES)

PHONE

IDENTIFY AGENCY CALLED TO SCENE (police, fire, etc.)

REPORT #

## INJURIES (complete separate form for each injured individual)

NAME	STUDENT	EMP.	OTHER
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NAME	GENDER	AGE	GRADE
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ADDRESS LAST FIRST MIDDLE HOME PHONE

NAME OF PARENT/GUARDIAN (if applicable) STREET CITY ZIP CODE WORK PHONE

PART OF BODY INJURED TYPE OF INJURY (e.g., cut, burn)

EXTENT OF INJURY (e.g., minor, severe) No. of SCHOOL DAYS LOST:

NAME OF PERSON IN CHARGE AT TIME OF ACCIDENT TITLE PHONE # PRESENT AT SCENE?  Yes  No

ACTION TAKEN / BY WHOM / WHEN

SENT TO SCHOOL NURSE  SENT HOME  911 CALLED  SENT TO HOSPITAL / DOCTOR. If STUDENT, ACCIDENT INS.  Yes  No

## NON-VEHICLE PROPERTY DAMAGE / LOSS

PROPERTY DESCRIPTION / DAMAGE SER # EST. LOSS \$

OWNER DISTRICT EMPLOYEE  Yes  No

ADDRESS PHONE: HOME WORK

## DAMAGE TO DISTRICT VEHICLE / OR OTHER VEHICLE (attach state accident report if available)

DISTRICT VEHICLE  To / FROM SCHOOL  PARKING LOT  OTHER YR MAKE MODEL Lic # VIN #

DRIVER NAME PHONE: HOME WORK

DESCRIBE DAMAGE EST. LOSS \$

CITATION / VIOLATION  DISTRICT DRIVER  OTHER DRIVER NAME

OTHER VEHICLE YR MAKE MODEL Lic # VIN #

OWNER / ADDRESS PHONE: HOME WORK

DRIVER (if not owner) / ADDRESS PHONE: HOME WORK

DESCRIBE DAMAGE

OTHER VEHICLE INSURANCE Co. POLICY #

INSURANCE AGENT / ADDRESS PHONE #

FORM COMPLETED BY \_\_\_\_\_ SUPERVISOR \_\_\_\_\_ DATE \_\_\_\_\_