

Form 530-2

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School Incident Report Form For Insurance Purposes

1	G E N E R A L	Name of School Division: _____	
		Name and Address of School: _____	
		Date of Incident M/D/Y: _____ Time _____ : _____ a.m. / p.m. Telephone # () - _____	
		Description of How Incident Occurred: _____	
<table border="0" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> Witnesses: (1) Name: _____ Teacher/Instructor/Other: _____ Witness Activity at Time: _____ (2) Name: _____ Teacher/Instructor/Other: _____ Witness Activity at Time: _____ </td> <td style="width: 50%; vertical-align: top;"> Location of Incident: L01 <input type="checkbox"/> Basement L02 <input type="checkbox"/> Cafeteria/Lunchroom L03 <input type="checkbox"/> Classroom L04 <input type="checkbox"/> Shops/Lab/Kitchen L05 <input type="checkbox"/> Doors/Entrance Areas L06 <input type="checkbox"/> Dormitories L07 <input type="checkbox"/> Gymnasium/Auditorium L08 <input type="checkbox"/> Hallways/Lockers L09 <input type="checkbox"/> Library/Office/Lounge/ Study Room L10 <input type="checkbox"/> Park/Grounds L11 <input type="checkbox"/> Parking Lot L12 <input type="checkbox"/> Playing Fields L13 <input type="checkbox"/> Playground Equipment L14 <input type="checkbox"/> Pool L15 <input type="checkbox"/> Rink L16 <input type="checkbox"/> Sidewalks/Roads Off Facility Property L17 <input type="checkbox"/> Stairs with Building L18 <input type="checkbox"/> Stairs/Sidewalks within Grounds L19 <input type="checkbox"/> Washrooms/Changing Rooms/Shower L20 <input type="checkbox"/> Other - (please explain) </td> </tr> </table>		Witnesses: (1) Name: _____ Teacher/Instructor/Other: _____ Witness Activity at Time: _____ (2) Name: _____ Teacher/Instructor/Other: _____ Witness Activity at Time: _____	Location of Incident: L01 <input type="checkbox"/> Basement L02 <input type="checkbox"/> Cafeteria/Lunchroom L03 <input type="checkbox"/> Classroom L04 <input type="checkbox"/> Shops/Lab/Kitchen L05 <input type="checkbox"/> Doors/Entrance Areas L06 <input type="checkbox"/> Dormitories L07 <input type="checkbox"/> Gymnasium/Auditorium L08 <input type="checkbox"/> Hallways/Lockers L09 <input type="checkbox"/> Library/Office/Lounge/ Study Room L10 <input type="checkbox"/> Park/Grounds L11 <input type="checkbox"/> Parking Lot L12 <input type="checkbox"/> Playing Fields L13 <input type="checkbox"/> Playground Equipment L14 <input type="checkbox"/> Pool L15 <input type="checkbox"/> Rink L16 <input type="checkbox"/> Sidewalks/Roads Off Facility Property L17 <input type="checkbox"/> Stairs with Building L18 <input type="checkbox"/> Stairs/Sidewalks within Grounds L19 <input type="checkbox"/> Washrooms/Changing Rooms/Shower L20 <input type="checkbox"/> Other - (please explain)
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2	S E C T I O N A	Name of Person Involved: _____ Age: _____ M/F: _____	
		Address: _____ Postal Code: _____ Grade/Year/Night School: _____ <small>(Schools Only)</small>	
		Student/Visitor/Other: (explain) _____ Division/Program: _____	
		Parent/Guardian/Emergency Contact: _____ Notified? <input type="checkbox"/> Yes <input type="checkbox"/> No How? _____	
		Telephone #: () - _____ Parent/Guardian/Emergency Contact Instructions: _____ Emergency Treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No What? _____ By Whom? _____ Advised to Seek Medical Treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No Where? _____ Hospitalized Overnight? <input type="checkbox"/> Yes <input type="checkbox"/> No How Transported? _____	
<table border="0" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> Nature of Injury/Damage: N01 <input type="checkbox"/> Bruise/Abrasion/Swelling N02 <input type="checkbox"/> Burn N03 <input type="checkbox"/> Concussion (suspected) N04 <input type="checkbox"/> Crushed N05 <input type="checkbox"/> Dental Damage N06 <input type="checkbox"/> Dislocation N07 <input type="checkbox"/> Fatality/Death N08 <input type="checkbox"/> Fracture N09 <input type="checkbox"/> Imbedded Object N10 <input type="checkbox"/> No Information N11 <input type="checkbox"/> Nosebleed N12 <input type="checkbox"/> Open Wound / Laceration N13 <input type="checkbox"/> Sprain/Strain (suspected) N14 <input type="checkbox"/> Winded N15 <input type="checkbox"/> Property DMB / Other Party N16 <input type="checkbox"/> Bites/Stings N17 <input type="checkbox"/> Other - (please explain) </td> <td style="width: 50%; vertical-align: top;"> Body Area: B01 <input type="checkbox"/> Arms/Shoulder/Elbow B02 <input type="checkbox"/> Chest/Abdomen/Pelvis B03 <input type="checkbox"/> Eyes B04 <input type="checkbox"/> Face B05 <input type="checkbox"/> Feet/Toes B06 <input type="checkbox"/> Fingers/Hands/Wrists B07 <input type="checkbox"/> Head/Forehead B08 <input type="checkbox"/> Legs/Knees/Ankles B09 <input type="checkbox"/> Multiple Areas B10 <input type="checkbox"/> Neck B11 <input type="checkbox"/> No Information B12 <input type="checkbox"/> Spine/Back B13 <input type="checkbox"/> Teeth/Mouth B14 <input type="checkbox"/> Other - (please explain) </td> </tr> </table>		Nature of Injury/Damage: N01 <input type="checkbox"/> Bruise/Abrasion/Swelling N02 <input type="checkbox"/> Burn N03 <input type="checkbox"/> Concussion (suspected) N04 <input type="checkbox"/> Crushed N05 <input type="checkbox"/> Dental Damage N06 <input type="checkbox"/> Dislocation N07 <input type="checkbox"/> Fatality/Death N08 <input type="checkbox"/> Fracture N09 <input type="checkbox"/> Imbedded Object N10 <input type="checkbox"/> No Information N11 <input type="checkbox"/> Nosebleed N12 <input type="checkbox"/> Open Wound / Laceration N13 <input type="checkbox"/> Sprain/Strain (suspected) N14 <input type="checkbox"/> Winded N15 <input type="checkbox"/> Property DMB / Other Party N16 <input type="checkbox"/> Bites/Stings N17 <input type="checkbox"/> Other - (please explain)	Body Area: B01 <input type="checkbox"/> Arms/Shoulder/Elbow B02 <input type="checkbox"/> Chest/Abdomen/Pelvis B03 <input type="checkbox"/> Eyes B04 <input type="checkbox"/> Face B05 <input type="checkbox"/> Feet/Toes B06 <input type="checkbox"/> Fingers/Hands/Wrists B07 <input type="checkbox"/> Head/Forehead B08 <input type="checkbox"/> Legs/Knees/Ankles B09 <input type="checkbox"/> Multiple Areas B10 <input type="checkbox"/> Neck B11 <input type="checkbox"/> No Information B12 <input type="checkbox"/> Spine/Back B13 <input type="checkbox"/> Teeth/Mouth B14 <input type="checkbox"/> Other - (please explain)
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3	S E C T I O N B	Property Involved (describe property involved and extent of loss and/or damage): _____	
		Fire Department Attended? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Report Number: _____	
		Were Police Notified? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Branch/Detachment: _____	
<table border="0" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> Case Number: _____ Date (M/D/Y): _____ Time: _____ : _____ a.m. / p.m. Were There Visible Signs of Forced Entry? <input type="checkbox"/> Yes <input type="checkbox"/> No What? (explain) _____ </td> <td style="width: 50%; vertical-align: top;"> Cause of Loss/Damage: C01 <input type="checkbox"/> Burglary/Forcible Entry C02 <input type="checkbox"/> Collapse C03 <input type="checkbox"/> Dishonesty/Infidelity C04 <input type="checkbox"/> Explosion C05 <input type="checkbox"/> Falling Object C06 <input type="checkbox"/> Fire/Lightning C07 <input type="checkbox"/> Glass Breakage C08 <input type="checkbox"/> Impact By Vehicle/Aircraft C09 <input type="checkbox"/> Riot C10 <input type="checkbox"/> Robbery C11 <input type="checkbox"/> Smoke C12 <input type="checkbox"/> Theft C13 <input type="checkbox"/> Transportation C14 <input type="checkbox"/> Vandalism/ Malicious Acts C15 <input type="checkbox"/> Water Escape/ Rupture/Freezing C16 <input type="checkbox"/> Windstorm/Hail C17 <input type="checkbox"/> Other - (please explain) </td> </tr> </table>		Case Number: _____ Date (M/D/Y): _____ Time: _____ : _____ a.m. / p.m. Were There Visible Signs of Forced Entry? <input type="checkbox"/> Yes <input type="checkbox"/> No What? (explain) _____	Cause of Loss/Damage: C01 <input type="checkbox"/> Burglary/Forcible Entry C02 <input type="checkbox"/> Collapse C03 <input type="checkbox"/> Dishonesty/Infidelity C04 <input type="checkbox"/> Explosion C05 <input type="checkbox"/> Falling Object C06 <input type="checkbox"/> Fire/Lightning C07 <input type="checkbox"/> Glass Breakage C08 <input type="checkbox"/> Impact By Vehicle/Aircraft C09 <input type="checkbox"/> Riot C10 <input type="checkbox"/> Robbery C11 <input type="checkbox"/> Smoke C12 <input type="checkbox"/> Theft C13 <input type="checkbox"/> Transportation C14 <input type="checkbox"/> Vandalism/ Malicious Acts C15 <input type="checkbox"/> Water Escape/ Rupture/Freezing C16 <input type="checkbox"/> Windstorm/Hail C17 <input type="checkbox"/> Other - (please explain)
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3	3	Name of Person Completing Report: _____ (Signature)	
		(Please Print or Type)	
		Name of Administrator: _____ (Signature)	
		(Please Print or Type)	
		Date: _____	