SANTA MARIA JOINT UNION HIGH SCHOOL DISTRICT

Clear Form

CONFIDENTIAL STUDENT ACCIDENT REPORT

INSTRUCTIONS: This report is to be completed when a student is involved in an accident or injury (please submit to the Health Office promptly)

School Site: ☐ Delta HS ☐ Pioneer Valley HS ☐ Ernest Righetti HS ☐ Santa Maria HS				
Student Last Name, First Name:				
ID#:	**Grade:**	**DOB:**	**Age:**	**Sex:** ☐ M ☐ F ☐ N
Address:			**City:**	**Zip:**
Home Phone No:				

DETAILS OF INCIDENT
(Attach Additional Sheet or Report if Necessary)

Date/Time of Incident:		
Location of Incident (specific)**:**		
Detailed Explanation of Incident:		
Reported to *(i.e., teacher, coach, health office, principal, police):*	Date Reported:	Time:
Did incident involve other student(s) or non-student(s)? ☐ Yes ☐ No IF YES, NAME(S):		
Did student report accident/injury to supervising teacher? ☐ Yes ☐ No; If Yes, Name(s):		
WAS EQUIPMENT OR MACHINERY INVOLVED? (PLAYGROUND, INDUSTRIAL ARTS, ETC.) ☐ Yes ☐ No IF YES, NOTE ANY DEFICIENCIES		
WAS A RULE OR PROCEDURE VIOLATED? ☐ Yes ☐ No; If Yes, EXPLAIN (Include horseplay)		

Full Name of Person(s) Present:	Title of Person (Teacher, Aide, etc.):	Present at time of incident? ☐ Yes ☐ No

REPORT PREPARED BY:	TITLE:	PHONE NUMBER:	DATE:

DISPOSITION

NATURE OF INJURY	INJURED PART OF BODY
☐ Abrasion ☐ Concussion ☐ Contusion ☐ Cut ☐ Dislocation ☐ Fracture ☐ Internal ☐ Sprain ☐ Other - Explain	☐ Left Side ☐ Right Side ☐ Abdomen ☐ Arm ☐ Back ☐ Chest ☐ Eye ☐ Face ☐ Finger ☐ Foot ☐ Hand ☐ Head ☐ Leg ☐ Neck ☐ Other - Explain

First Aid Provided: ☐ Yes; If Yes, Provided by: ☐ No; Reason:		
Name of Parent/Guardian Notified:	Date/Time Contacted:	Notified by:
Parent/Guardian Comments:		
Disposition: ☐ Return to Class ☐ Home ☐ Doctor ☐ 911/Hospital ☐ Other:		
Transported By:		
COMMENTS:		
HEALTH OFFICE SIGNATURE:		
SITE ADMINISTRATOR SIGNATURE:		

FOR INTERNAL USE ONLY

Claim # _____

STUDENT ACCIDENT CLAIM FORM

(Grades Preschool through 12)

☐ Supplemental Coverage

Mail To: SISC Student Accident Claims, P.O. Box 1847,
Bakersfield, CA 93303-1847 - (661) 636-4710

TO BE COMPLETED BY SCHOOL OFFICIAL

Did the accident occur **during** (*Check Yes or No*)

A. Non-school related activity?	❑ Yes	❑ No
B. Supervised school activity?	❑ Yes	❑ No
C. Field trip activity?	❑ Yes	❑ No
D. Supervised off-campus activity?	❑ Yes	❑ No
E. Sponsored and supervised travel?	❑ Yes	❑ No
F. Supervised athletic practice/competition?	❑ Yes	❑ No

Sport_____

Name and Title of Supervising School Authority:

Name_____

Title _____

Signature _____

School District Santa Maria Joint Union High School District

School Name_____

STUDENT'S FULL NAME | MAILING ADDRESS | CITY | ZIP

DATE OF BIRTH | SOCIAL SECURITY # | GRADE | SEX ❑ M ❑ F ❑ N | TELEPHONE

1. Give full description of injury. Tell when, where, and how it happened.

2. Give exact date and time when injury occurred. Date: _____ Time:_____ a.m. _____p.m.

3. When did the student first consult a physician for this condition? Date: _____

Completed by_____ Date _____

TO BE COMPLETED BY PARENT(S) / GUARDIAN(S)

SISC Accident Coverage is secondary to your private health insurance.

1. Father/Guardian Name _____ EMPLOYED: Yes_____ No_____

Employer _____ Employer Telephone (_____)_____

Individual and/or
Group Insurance Company _____ Policy # _____

SOCIAL SECURITY # _____Is child covered by this insurance? Yes_____ No_____

I authorize the release of any information necessary to process this claim.

Signature_____Date_____

I authorize payment of medical benefits to physician or supplier of service.

Signature_____Date_____

2. Mother/Guardian Name_____ EMPLOYED: Yes_____ No_____

Employer _____ Employer Telephone (_____)_____

Individual and/or
Group Insurance Company _____ Policy # _____

SOCIAL SECURITY # _____Is child covered by this insurance? Yes_____ No_____

I authorize the release of any information necessary to process this claim.

Signature_____Date_____

I authorize payment of medical benefits to physician or supplier of service.

Signature_____Date_____

IMPORTANT: All hospital and doctor bills must be itemized.
NOTICE TO PROVIDERS: A copy of this claim form needs to be attached to your bill.

Reclamo # _____

FORMULARIO DE RECLAMACIÓN ACCIDENTE ESCOLAR

(Grados Preescolar - 12)

☐ Cobertura Suplementaria

Enviar a: SISC Student Accident Claims, P.O. Box 1847,
Bakersfield, CA 93303-1847 - (661) 636-4710

TO BE COMPLETED BY SCHOOL OFFICIAL – LO DEBE LLENAR UN FUNCIONARIO ESCOLAR

Did the accident occur **during** (*Check Yes or No*)

A. Non-school related activity?	❑ Yes	❑ No
B. Supervised school activity?	❑ Yes	❑ No
C. Field trip activity?	❑ Yes	❑ No
D. Supervised off-campus activity?	❑ Yes	❑ No
E. Sponsored and supervised travel?	❑ Yes	❑ No
F. Supervised athletic practice/competition?	❑ Yes	❑ No

Sport_____

Name and Title of Supervising School Authority:

Name_____

Title _____

Signature _____

School District Santa Maria Joint Union High School District

School Name_____

STUDENT'S FULL NAME	MAILING ADDRESS	CITY	ZIP

DATE OF BIRTH	SOCIAL SECURITY #	GRADE	SEX	TELEPHONE
			❑ M ❑ F ❑ N	

1. Give full description of injury. Tell when, where, and how it happened.

2. Give exact date and time when injury occurred. Date: _____ Time:_____ a.m. _____p.m.

3. When did the student first consult a physician for this condition? Date: _____

Completed by_____ Date _____

TO BE COMPLETED BY PARENT(S) / GUARDIAN(S) – LO DE BE LLENAR PADRE / MADRE O TUTOR LEGAL

La cobertura SISC para accidentes escolares es suplemental a su seguro médico privado.

1. Nombre del padre/tutor _____ TRABAJA: Sí_____ No_____

Empleador_____ Número de teléfono de la compañía _____

Compañía de seguro
de plan Individual y/o de grupo _____ # de Póliza_____

de Seguro Social _____ ¿El menor tiene cobertura médica mediante este plan? Sí_____ No_____

Autorizo que se divulgue cualquier información necesaria para procesar este reclamo.

Autorizo el pago de beneficios médicos para el médico o el suministrador de servicio.

Firma _____ Fecha _____ Firma _____ Fecha _____

2. Nombre del madre/tutor _____ TRABAJA: Sí_____ No_____

Empleador_____ Número de teléfono de la compañía _____

Compañía de seguro
de plan Individual y/o de grupo _____ # de Póliza_____

de Seguro Social _____ ¿El menor tiene cobertura médica mediante este plan? Sí_____ No_____

Autorizo que se divulgue cualquier información necesaria para procesar este reclamo.

Autorizo el pago de beneficios médicos para el médico o el suministrador de servicio.

Firma _____ Fecha _____ Firma _____ Fecha _____

IMPORTANTE: Todas las facturas del hospital y el médico deben ser detalladas.
AVISO A LOS PROVEEDORES: Envíe una copia de este formulario al enviar las facturas médicas.

File # _____

SISC TACKLE FOOTBALL CLAIM FORM

Mail To: SISC Tackle Football, P.O. Box 1847,
Bakersfield, CA 93303-1847 - (661) 636-4710

TO BE COMPLETED BY SCHOOL OFFICIAL

Did the accident occur **during** (*Check Yes or No*)

A. School sponsored tackle football practice?
☐ Yes ☐ No

B. School sponsored tackle football competition?
☐ Yes ☐ No

C. School sponsored and supervised tackle football transportation?
☐ Yes ☐ No

Name and Title of Supervising School Authority:

Name _____

Title _____

Signature _____

School District Santa Maria Joint Union High School District

School Name _____

STUDENT'S FULL NAME	MAILING ADDRESS	CITY	ZIP

DATE OF BIRTH	SOCIAL SECURITY #	GRADE	SEX	TELEPHONE
			☐ M ☐ F ☐ N	

1. Give full description of injury. Tell when, where, and how it happened.

2. Give exact date and time when injury occurred. Date: _____ Time: _____ a.m. _____ p.m.

3. When did the student first consult a physician for this condition? Date: _____

Completed by _____ Date _____

TO BE COMPLETED BY PARENT(S) / GUARDIAN(S)

SISC Accident Coverage is secondary to your private health insurance.

1. Father/Guardian Name _____ EMPLOYED: Yes_____ No_____

Employer _____ Employer Telephone (_____) _____

Individual and/or
Group Insurance Company _____ Policy # _____

SOCIAL SECURITY # _____ Is child covered by this insurance? Yes_____ No_____

I authorize the release of any information necessary to process this claim.

Signature_____Date_____

I authorize payment of medical benefits to physician or supplier of service.

Signature_____Date_____

2. Mother/Guardian Name _____ EMPLOYED: Yes_____ No_____

Employer _____ Employer Telephone (_____) _____

Individual and/or
Group Insurance Company _____ Policy # _____

SOCIAL SECURITY # _____ Is child covered by this insurance? Yes_____ No_____

I authorize the release of any information necessary to process this claim.

Signature_____Date_____

I authorize payment of medical benefits to physician or supplier of service.

Signature_____Date_____

IMPORTANT – PARENT'S RESPONSIBILITY: Injuries MUST be treated by a properly authorized Physician or Dentist. All hospital and doctor bills must be itemized.