

# Alaska Gateway School District

## STUDENT ACCIDENT PROCEDURE

When a student is injured on AGSD property or at a school sponsored event, there are several steps that need to be followed to ensure that the District is protected and the student is taken care of.

- If the injury is minor, make the student as comfortable as possible. Essential first aid is to be administered by the Principal or by a staff member designated by the Principal to do so.
- Notify the parents, guardian or emergency contact.
- Complete the AGSD Student Accident Report Form. Send the form to Deb Sparks or Robbie MacManus at Central Office.
- In case of severe injury, make the pupil as comfortable as possible, call for an ambulance (if necessary) and follow the procedures listed below.
- Complete the AML/JIA Student Accident Coverage – Accident claim form Part A – School Statement.
- Call District Office (907) 883-5151 to report the ambulance call.
- Follow the steps listed below regarding incident investigation and witness reports;

It is imperative that an incident investigation takes place and that an incident report is filled out by the staff member that witnessed the accident or site administrator if no one witnessed. Documentation is essential. The investigation should take place as soon as possible, which means immediately after care is given to the student. Documenting the physical status of the area with photos will record the condition of the area, playground, bus, etc. Be sure to get witness statements from anyone else that may have witnessed the incident.

It is also necessary to have the parent/guardian complete Part B of the AML/JIA form. Give a copy of the completed form to the parent/guardian.

Once this form is complete forward the original to Robbie MacManus and she will send to Meyers-Stevens & Toohey & Co. Do not keep a copy of the AML/JIA form in the student's file. You can keep a copy of the accident report in their file.

# ALASKA GATEWAY SCHOOL DISTRICT

## Student Accident Report Form

School: \_\_\_\_\_ Date of Accident: \_\_\_\_\_ Time: \_\_\_\_\_

Name of Student: \_\_\_\_\_ Age: \_\_\_\_\_

Was student under teacher supervision at the time of accident? Yes \_\_\_\_\_ No \_\_\_\_\_

Name of Teacher: \_\_\_\_\_ Did Teacher see accident? Yes \_\_\_\_\_ No \_\_\_\_\_

Teacher's description of accident: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Description of accident by injured student: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Description of accident by student seeing accident: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Brief statement of seriousness of injury: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Was First Aid treatment given? Yes \_\_\_\_\_ No \_\_\_\_\_

Was additional medical attention necessary? Yes \_\_\_\_\_ No \_\_\_\_\_

Describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Was parent notified? Yes \_\_\_\_\_ No \_\_\_\_\_ How soon? \_\_\_\_\_

Report any accident which could be considered serious. Signed: \_\_\_\_\_  
School Administrator

Myers-Stevens & Toohy & Co.  
26101 Marguerite Parkway  
Mission Viejo, CA 92692-3203  
Ph: 800-827-4695 Fax: 949-348-2630



Instructions:  
1) Complete this form  
2) Attach all bills  
3) Mail to: Myers-Stevens & Toohy

## STUDENT ACCIDENT COVERAGE – ACCIDENT CLAIM FORM

### PART A ~ SCHOOL STATEMENT

<b>1</b> Injured Student Name: First MI Last	Student Soc. Security #	Student DOB:
<b>2</b> Name of AML/JIA Member School District:	Student Age & Grade:	<input type="checkbox"/> Male <input type="checkbox"/> Female
<b>3</b> Injury Occurred: <input type="checkbox"/> practice <input type="checkbox"/> game <input type="checkbox"/> P.E. <input type="checkbox"/> classroom <input type="checkbox"/> travel <input type="checkbox"/> field trip <input type="checkbox"/> at home <input type="checkbox"/> other	Date of Injury: month/day/year	Time of Injury:
Details on how the injury occurred: (please be specific)	What part of the body was injured?	School telephone number: School FAX number:
<b>4</b> Name of Supervisor/Teacher (school):	Date school was notified of incident:	Did Supervisor/teacher witness incident?
<b>5</b> Name of Official/Superintendent/Principal	Signature of official: <b>X</b>	Date Signed:

### PART B ~ PARENT OR GUARDIAN STATEMENT

<b>6</b> Relationship to Injured Student: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Guardian <input type="checkbox"/> Other	Is this dependent covered by another health and/or accident insurance plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>7</b> Name of <u>Father or Male</u> Guardian:	SSN:	Home Telephone Number: ( )
Address:	City/State:	Zip Code:
<b>8</b> Name of Employer:	Work Telephone Number: ( )	
Address of Employer:	City/State:	Zip Code:
<b>9</b> Name of other health/accident coverage:	Policy Number:	Telephone Number: ( )
<b>10</b> Address of other coverage:	City/State:	Zip Code:
<b>11</b> Name of <u>Mother or Female</u> Guardian:	SSN:	Home Telephone Number: ( )
Address:	City/State:	Zip Code:
<b>12</b> Name of Employer:	Work Telephone Number: ( )	
Address of Employer:	City/State:	Zip Code:
<b>13</b> Name of other health/accident coverage:	Policy Number:	Telephone Number: ( )
<b>14</b> Address of other coverage:	City/State:	Zip Code:
<b>15</b> Name, address and telephone number of family physician:		
<b>16</b> Has the student suffered from same or similar condition before? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, when?		
I understand that any parent who knowingly, and with intent to defraud any insurance company or other person, files a statement of a claim containing any materially false information, or conceals, for the purpose of misleading, information concerning facts material, thereto commits a fraudulent act, which is a crime, and may subject such person to fines and/or imprisonment.		Signature of Parent or Guardian: <b>X</b>
I hereby authorize any school authority, employer, or insurance company, or person who has attended to or examined the claimant to disclose to Myers-Stevens & Toohy & Co., Inc. or the AML/JIA, when requested to do so, any information regarding any injury or illness, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records or itemized bills, and to pay benefits based upon this information. Photocopy of this authorization shall be considered as valid and effective as the original.		Relationship to injured student:
Authorization to pay benefits to provider: I authorize payment of Medical payments to Physician or Supplier for services on the attached.		Signature of Parent or Guardian: <b>X</b>