Summit Academy

Student Incident Report

Today's Date:_____

Named Insured: Summit Academy

Date of Incident:_____ Time of Incident: _____

Location of Incident:_____

City:_____ State:_____ Zip:_____

Injured Person: _____

Date of Birth:_____ Grade:_____

Sex:_____

Address:_____

City:_____ State:_____ Zip:_____

Description of Incident:_____

_____

_____

_____

Was medical treatment offered?_____ Accepted?_____

What medical treatment was offered?_____

_____

_____

What medical facility provided treatment?_____

_____

List any witnesses:

Name:_____ Phone:_____

Name:_____ Phone:_____

What action was taken?_____

_____

_____

Is it likely that a claim will result from this incident?

Yes No Uncertain

Claim Contact Person:

Name:_____ Phone:_____

Please fax within 24 hours to Central Office