Douglas County School District
RISK RELATED ACTIVITIES

620 Wilcox St.; Castle Rock, CO 80104
Phone 303 387-0030 / Fax 303 387-0112

Liability Claim Form Resulting From Injury

NAME OF SCHOOL/LOCATION

WHO WAS INJURED?	**WHEN DID THE ACCIDENT HAPPEN?**
Name: (First, Middle, Last)	Date of Accident
Home Address	Time of Accident
City/State/Zip	Report Date
Phone Number (home)	If Athletic Injury, what Sport?
Student ☐ Visitor/Volunteer ☐	
Sex Male ☐ Female ☐ If student, grade	If Athletic Injury, was it a Practice ☐ or Event ☐

WHERE DID THE ACCIDENT HAPPEN?

Field ☐
Bathroom ☐
Cafeteria ☐
Classroom ☐
Corridor/hall ☐
Gym\Locker Room ☐
Metal/Woodshop ☐
Other: _____

Specific Body Part Injured	**Nature of Injury**
List all parts of body injured and whether left or right side:	(Abrasion, bruise, cut, fracture, sprain, etc.)
_____	_____
_____	_____
_____	_____

911 CALLED? YES ☐ NO ☐ BY_____
FIRST AID TREATMENT? YES ☐ NO ☐ BY_____
SENT HOME? YES ☐ NO ☐ BY_____
SENT TO HOSPITAL/DR? YES ☐ NO ☐ BY_____
PARENT/OTHER NOTIFIED? YES ☐ NO ☐ BY_____
RELATIONSHIP _____
TIME NOTIFIED _____
PICKED UP FROM SCHOOL? YES ☐ NO ☐ BY_____

WHAT HAPPENED? (Provide Detailed Description of the How the Accident Happened, What Happened, and Who was Involved)

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SUPERVISION AND WITNESS INFORMATION	**FOR RISK MANAGEMENT USE**
Did accident happen - Before School☐ After School☐ During School☐	Date Entered
Name of Employee(s) on Duty None ☐	Other Information _____
Did employee(s) witness accident? Yes ☐ No ☐	

SIGNATURES REQUIRED

SIGNATURE/TITLE OF PERSON COMPLETING REPORT	DATE
SIGNATURE/TITLE OF EMPLOYEE IN CHARGE WHEN ACCIDENT OCCURRED	DATE
PRINCIPAL'S SIGNATURE	DATE

For more information visit: http://www.dcsdk12.org