LOMA LINDA ACADEMY

Instructions for Reporting Student Injuries

ACTIVITY SUPERVISOR:

1. Inform Division Administrator
2. Fill out ***LLA Injury Report*** – return the form to the Division Administrator

DIVISION ADMINISTRATOR:

1. Inform parent of their student's injury
2. Fill out ***Myers-Stevens & Toohey & Co., Inc. Student Insurance Claim Form***.
3. Give *Student Insurance Claim Form* to parent and instruct them to fill out the bottom portion.
4. Inform parent this insurance is secondary to their primary insurance.
5. Inform parent to send the completed Student Insurance Claim along with all bills attached to the address on top of the claim form.
6. Send copy of the *Student Insurance Claim Form* to the Health Office and put a copy of the form in the student's file.

LOMA LINDA ACADEMY

STUDENT INJURY REPORT

- ☐ Submitted to Division Administrator
- ☐ Copy given to Health Office
- ☐ Student insurance claim form given to parent as secondary insurance.

This form is to be completed when a student suffers more than a minor injury while at school or involved in a school sponsored activity.

Student's Name_____ M( ) F( ) Date of Birth_____/_____/_____ Grade _____

School Name _____ Date of Injury _____/_____/_____ Time: _____AM _____PM

Student's Address: _____ ZIP_____ Phone_____

Body Part Injured: (Identify R or L if applicable)

Head	Trunk	Extremities	
_____Ear	_____Abdomen	_____Upper Arm	_____Hip
_____Eye	_____Back	_____Elbow	_____Upper Leg
_____Face	_____Chest	_____Lower Arm	_____Knee
_____Head	_____Groin	_____Wrist	_____Lower Leg
_____Mouth	_____Ribs	_____Hand	_____Ankle
_____Neck	_____Shoulder	_____Finger_____	_____Foot
_____Nose		_____Thumb	_____Toe_____

Type of Injury Suspected:

_____Abrasion	_____Cut/Laceration	_____Puncture
_____Bee sting	_____Dislocation	_____Scratch/Surface cut
_____Bruise/contusion	_____Fracture (possible)	_____Sliver/Foreign body
_____Burn	_____Inflammation	_____Sprain/Strain
_____Concussion	_____Irritation	_____Other _____

First Aid Given

_____Bandage/Applied dressing	_____Cold pack/Ice	_____Rest_____(minutes)
_____Cleansed/Washed wound	_____Direct Pressure	_____Splint/Immobilize

_____Other_____

Action taken:

_____Returned to class _____ time	_____Parent took to physician _____ time	_____Called 911_____ time
_____Parent/Guardian called _____ time	_____Parent took to ER _____ name of hospital	_____Transferred to hospital _____ name of hospital
_____Parent/Guardian took home _____ time		

Place Where Accident Happened:

_____Blacktop	_____Doors/Hallway	_____Lockers	_____Restrooms
_____Cafeteria (Lunch tables)	_____Field	_____Multi-purpose room	_____Stairs
_____Classroom	_____Gym	_____Playground equipment	_____Other_____

Explanation of Accident:

_____Collision with person	_____Collision with obstacle	_____Tripped/slipped
_____Hit with object	_____Fall _____(height of fall)	_____Other_____

Activity or Equipment Involved:

_____Altercation	_____Cross-country	_____Football	_____Running	_____Tetherball	Other_____
_____Basketball	_____Dodgeball	_____Gymnastics	_____Soccer	_____Track & Field	_____
_____Calisthenics	_____Field Trip	_____Kickball	_____Softball	_____Volleyball	_____

Any additional description of accident (when, where, why, who or how):

_____

_____

_____

Name of person supervising the student at time of injury: _____ Title: _____

Approximate number of students being supervised at the time of accident _____ Did supervisor directly witness accident? _____Yes _____No

Signature of person completing form _____ Title: _____

Date: _____

SDrive > Administration All > CC-12 Employee Forms

myers | stevens | toohey

STUDENT ACCIDENT & SICKNESS INSURANCE CLAIM FORM

PART A SCHOOL/PARISH STATEMENT

(Parent or legal guardian may complete Part A if injury is not school/parish-related)

NAME OF CLAIMANT FIRST	MI	LAST	AGE	GRADE	☐ FEMALE ☐ MALE	DATE OF BIRTH MO DAY YR

ADDRESS OF CLAIMANT | CITY | STATE | ZIP CODE

IS THE CLAIMANT A: ☐ STUDENT ☐ STAFF ☐ VOLUNTEER ☐ OTHER _____

ID # FROM ID CARD (If applicable)

NAME OF SCHOOL/PARISH

NAME OF DISTRICT, DIOCESE OR OTHER SCHOOL SYSTEM

SCHOOL/PARISH MAILING ADDRESS | CITY | STATE | ZIP CODE

SCHOOL CONTACT EMAIL ADDRESS

DURING WHAT ACTIVITY DID THE INJURY OCCUR? ☐ INTERSCHOLASTIC PRACTICE ☐ INTERSCHOLASTIC GAME ☐ P.E. ☐ CLASSROOM ☐ PLAYGROUND ☐ TRAVEL ☐ AT HOME ☐ FIELD TRIP ☐ RELIGIOUS EDUCATION ☐ CONFIRMATION ☐ YOUTH MINISTRY ☐ YOUNG ADULT MINISTRY ☐ CYO ☐ PAL ☐ OTHER _____

WAS THE CLAIMANT PARTICIPATING IN A SPORT NOT SCHOOL/PARISH-SPONSORED AND SUPERVISED? ☐ YES ☐ NO
IF YES, LIST NAME OF SPORTS ORGANIZATION:

TYPE OF SPORT:

DOES THE SCHOOL/PARISH HAVE ANY RECORD OF ANY HEALTH COVERAGE FOR THE CLAIMANT? ☐ YES ☐ NO
If YES, name of plan:

DATE OF INJURY/SICKNESS

TIME OF INJURY ◯ / ◯ (Circle One)

WHAT **PART** AND/OR **AREA** OF THE BODY WAS INJURED? (Additional details may be provided below) ☐ RIGHT _____ ☐ LEFT _____

HAS THE CLAIMANT SUFFERED FROM SAME OR SIMILAR CONDITION BEFORE? ☐ YES ☐ NO IF YES, WHEN?

PROVIDE DETAILS ON HOW AND WHERE THE INJURY OR ILLNESS OCCURRED. PLEASE BE SPECIFIC

NAME AND TITLE OF SUPERVISING OFFICIAL AT TIME OF INJURY

WAS HE/SHE A WITNESS TO THE ACCIDENT? ☐ YES ☐ NO

DATE SCHOOL/PARISH WAS NOTIFIED

NAME AND TITLE OF OFFICIAL COMPLETING FORM

SIGNATURE X

DATE SIGNED

SCHOOL/PARISH TELEPHONE NUMBER

PART B PARENT OR LEGAL GUARDIAN INFORMATION

NAME OF CLAIMANT'S PRIMARY PHYSICIAN | ADDRESS | PHONE NUMBER

IS THE CLAIMANT COVERED, DIRECTLY AND/OR AS A DEPENDENT UNDER ANY OTHER INSURANCE OR HEALTH PLAN(S)? ☐ YES ☐ NO
IF YES, NAME OF PLAN(S)

POLICY NUMBER(S)

IS THE CLAIMANT A MEDICARE BENEFICIARY? ☐ **YES** ☐ **NO**

NAME OF CLAIMANT'S EMPLOYER (if applicable) | ADDRESS | PHONE NUMBER

NAME OF FATHER OR LEGAL MALE GUARDIAN | EMAIL ADDRESS | MOBILE TELEPHONE NO. | HOME TELEPHONE NO.

ADDRESS | CITY | STATE | ZIP CODE

NAME OF EMPLOYER ☐ Self Employed ☐ Part Time ☐ Unemployed

WORK TELEPHONE

ADDRESS OF EMPLOYER | CITY | STATE | ZIP CODE

NAME OF MOTHER OR LEGAL FEMALE GUARDIAN | EMAIL ADDRESS | MOBILE TELEPHONE NO. | HOME TELEPHONE NO.

ADDRESS | CITY | STATE | ZIP CODE

NAME OF EMPLOYER ☐ Self Employed ☐ Part Time ☐ Unemployed

WORK TELEPHONE

ADDRESS OF EMPLOYER | CITY | STATE | ZIP CODE

AUTHORIZATION: I hereby authorize any School, Participating Organization, Policyholder, trust, employer, insurance company, health plan, medical/dental provider or other person or entity to release any information/documentation needed to process this claim to Myers-Stevens & Toohey Co., Inc. (MST) or its insuring company when requested by them to do so. This may include but is not limited to: details of the reported loss; identification of witnesses and supervisors; verification of other insurance or health coverage; coverage terms; explanations of benefits; complete health records including those involving mental/emotional disorders and substance abuse; prescription drug history and fully itemized bills in the form of CMS/HCFA 1500s and UB04s. If the claim is reportedly the result of participating in a School, Participating Organization or Policyholder activity, I authorize MST to share information concerning this claim as necessary with representatives of the School, Participating Organization or Policyholder as applicable. I understand that the authorization to release claim-related information/documentation to MST will terminate two years from the date of signature unless terminated in writing on an earlier date by me. A photo static/digital copy of this authorization shall be considered as valid and effective as the original.

NAME _____ RELATIONSHIP TO CLAIMANT _____ SIGNATURE X _____ DATE _____

ASSIGNMENT OF BENEFITS: I authorize the payment of benefits directly to the provider(s) of services and/or supplies associated with this claim.

NAME _____ RELATIONSHIP TO CLAIMANT _____ SIGNATURE X _____ DATE _____

FRAUD WARNING: Any person who knowingly and with intent to defraud any insurance company or other persons, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, subject to criminal prosecution and/or civil penalties.
I have read and acknowledge the General Fraud Warning above and the specific version for my state on the reverse side.

NAME _____ RELATIONSHIP TO CLAIMANT _____ SIGNATURE X _____ DATE _____