

Catholic Mutual Group
1011 First Avenue-19th Floor
New York, NY 10022

Fax Report by next business day to: Catholic Mutual at 212-826-8379

INTERNAL FORM – To be completed by Pastor, Principal or Manager

ACCIDENT REPORT
(for Students, CCD & CYO Participants)

School Name: _____ School ID # _____

Person Reporting: _____ Title/Position: _____

Phone #: _____ Date of Accident: _____ Time: _____

Party Involved-Name: _____ Student: YES or NO (If NO, describe) _____

If Student-Was parent notified? _____ By whom? _____

Student Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Parent Work #: _____

Student Date of Birth: _____ Social Security #: _____

Location and Description of
Accident: _____

Injury Damage: _____ Photos Taken? YES or NO

Transported by Ambulance? YES or NO

If yes, please list Ambulance Service and where transported to: _____

WITNESSES (please include address and phone numbers)

1) _____

2) _____

3) _____

Name of staff on duty: _____ First Aid given? YES or NO

Type of First Aid Administered: _____

First Aid Administered by: _____

Additional Information: _____

Was Student Accident Claim form given to parents? YES or NO