**SCHOOL STUDENT ACCIDENT REPORT FORM**

### 1. Give full description of injury from which you are now suffering. State when, where and how it happened.

- **INJURY**: [Blank]
- **HOW SUSTAINED**: [Blank]
- **FULL DESCRIPTION**: [Blank]
- **WHERE**: [Blank]

### 2. (a) Have you ever had this, or a similar condition, in the past?

- **YES**: Condition(s)
- **NO**: Dates: Treated by:

### 3. (a) Give exact date when injury occurred

- **(b) When was the student first consulted a physician for this condition?**
- **(c) When did you become totally disabled (unable to attend school)?**
- **(d) When were you able to return school?**
- **(e) If still totally disabled, when do you expect your disability to terminate?**

### 4. (a) Give names, addresses and telephone numbers of all attending physicians.

- **NAMES**: [Blank]
- **ADDRESSES**: [Blank]
- **TELEPHONE**: [Blank]

### 5. (a) Have you claimed yet?

- **YES**: Give Membership No. and Branch
- **NO**: Have you claimed yet?

### INFORMATION AUTHORITY AND WARRANTY

I, ................................................................................................................................. hereby authorise any hospital, physician or other person who has attended me / the Insured Person, to furnish AIG Australia or its representatives with any hospital and medical reports/notes and/or any information pertaining to my medical history (any sickness or disease or injury, consultation, prescription or treatment). I agree that a Photocopy of this authorisation shall be considered as effective and valid as the original and specifically authorise its use as such.

I declare and warrant that the foregoing particulars are true and correct in every detail and acknowledge that the AIG Australia relies upon the truthfulness of the particulars supplied by me in respect of the claim.

### PRIVACY CONSENT

I consent to AIG Australia:

(a) Collecting and using my personal information for the purposes of administering my claim including investigating, assessing and paying any claim made by me or on my behalf. If we do not collect this information we may not be able to process your claim.

(b) Disclosing my personal information to related entities of AIG Australia, their staff members located outside Australia, the insured, other insurers and reinsurers, insurance reference bureaus, law enforcement agencies, investigators, lawyers, assessors, repairers, advisors and the agent of any of these, insurance broker, insurance agent or other intermediary, or Insurance Ombudsman Service Ltd for the purposes of administering my claim or providing a report.

(c) I understand that AIG Australia is a signatory to the General Insurance Information Privacy Code and that a copy of the AIG Australia’s privacy policy statement, including information about access, may be obtained by writing to the Privacy Manager AIG Australia 549 St Kilda Road Melbourne or by e-mailing australia.privacy.manager@aig.com.

(Where applicable) I do solemnly and sincerely declare that I am the parent/legal guardian of the Insured Person and provide this information on his/her behalf.

Dated: .................................... Name (please print): ........................................................................... Signed: ............................................................

### PLEASE ENSURE THAT ALL QUESTIONS HAVE BEEN FULLY ANSWERED

I certify that ....................................................................................................................... is/was enrolled at this school at the time of the injury.

**NAME OF SCHOOL**: .................................................................................................

**NAME** ..............................................................................................................................

**ADDRESS** ......................................................................................................................

**Phone Number** ..............................................................................................................

I HEREBY CERTIFY THAT the particulars shown on this form, are to the best of my belief and knowledge, true and correct.

**SIGNATURE** .......................................................................................................................

**DATE** ........................................ / / ........................................

**WITNESS** ..........................................................................................................................
### ATTENDING PHYSICIANS STATEMENTS

**THE INSURED IS RESPONSIBLE FOR COMPLETING OF THIS FORM WITHOUT EXPENSE TO THE COMPANY**

**PATIENT’S NAME AND ADDRESS**

<table>
<thead>
<tr>
<th>1. When did patient suffer the injury?</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. What were the circumstances surrounding the injury?</td>
</tr>
<tr>
<td>3. When did patient first receive medical treatment?</td>
</tr>
<tr>
<td>4. Please give a complete diagnosis of this condition</td>
</tr>
<tr>
<td>5. Please give results of any objective findings</td>
</tr>
<tr>
<td>(a) X-Rays</td>
</tr>
<tr>
<td>(b) Other Tests — Please advise tests done and findings</td>
</tr>
<tr>
<td>6. Was patient confined to hospital? YES / NO</td>
</tr>
<tr>
<td>(a) If YES, please advise: (a) Name and address of hospital</td>
</tr>
<tr>
<td>(b) Period of Confinement From To</td>
</tr>
<tr>
<td>7. What other treatment has patient undergone?</td>
</tr>
<tr>
<td>8. What other treatment is required?</td>
</tr>
</tbody>
</table>

**HISTORY**

| 1. (a) Was there a previous history of this or similar condition? YES / NO |
| (b) If YES, please state condition and advise when the previous treatment was given |
| 2. (a) How long have you known the patient? |
| (b) Are you the regular general practitioner? YES / NO If not, please advise who is |

**DEGREE OF DISABILITY**

| 1. When was patient obliged to cease school? |
| 2. If Patient is still unfit for school, when approximately will the patient be able to resume? |
| 3. If Patient has recovered, when was patient able to resume school? |

Are there any underlying conditions affecting recovery from the current condition? YES / NO

If YES, please advise nature of underlying conditions and how they affect disability and recovery

Please advise names and addresses of other treating physicians

If you have terminated treatment, please advise date

What is the current prognosis?

Are there any further remarks which may assist in assessing this condition?

Is there any permanent disability at presents? YES / NO

If YES, please explain giving estimated percentage loss of function

**Date: __________________________ Signature: __________________________ Degree: __________________________**

**Name (please print) __________________________**

**Street Address __________________________ City/Town __________________________ State __________________________**

**Phone No. __________________________**