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# K&K INCIDENT REPORT

Wisconsin Interscholastic Athletic Association  
Concussion Coverage

(PLEASE PRINT)

NATURE	<input type="checkbox"/> BODILY INJURY <input type="checkbox"/> OTHER: _____
TIME & PLACE OF INCIDENT	DATE: _____ TIME: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM EVENT NAME: _____ EVENT TYPE: _____ CONDUCTED BY: _____ LOCATION: _____
HAPPENED TO	NAME: _____ SSN: _____ DATE OF BIRTH: _____ SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female PHONE: ( ) _____ ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
FUNCTION	AS: <input type="checkbox"/> ATHLETE <input type="checkbox"/> OTHER: _____
APPARENT INJURY OR DAMAGE	BODY PART: _____ CONDITION: _____ <input type="checkbox"/> ON-SITE CARE ONLY, BY (PHYSICIAN) (EMT) (TRAINER) OTHER: _____ <input type="checkbox"/> AMBULANCE, TAKEN TO: _____ CITY: _____ <input type="checkbox"/> FATALITY
OCCASION	WHAT WAS THE SITUATION AND EXACT LOCATION AT THE TIME OF THE INCIDENT? _____ _____ _____ _____
INCIDENT DESCRIPTION	DESCRIBE WHAT HAPPENED: _____ _____ _____ _____
OTHER SCHOOL INSURANCE	DOES THE SCHOOL PROVIDE ANY OTHER ACCIDENT MEDICAL COVERAGE FOR THE STUDENTS? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, PLEASE PROVIDE THE NAME OF THE COMPANY: _____ _____ _____
INSURED	NAME OF INSURED: <u>WIAA</u> POLICY#: <u>6A-BAX-00000308821-00</u> WHSAA MEMBER SCHOOL NAME: _____ PHONE: ( ) _____ CITY: _____ STATE: _____
INSURED REPRESENTATIVE	<input type="checkbox"/> WHSAA Member <u>School</u> Administrator <input type="checkbox"/> OTHER: _____ NAME: _____ PHONE: ( ) _____ TITLE: _____ ORGANIZATION: _____ SIGNATURE: _____ DATE: _____

**COMPLETE ALL SECTIONS AND FAX OR MAIL IMMEDIATELY TO:**

**K&K INSURANCE GROUP, INC., P.O. BOX 2338, FORT WAYNE, IN 46801-2338**

**THIS FORM MUST INCLUDE THE INSURED NAME, POLICY NUMBER, AND SIGNATURE OF THE INSURED/REPRESENTATIVE  
BEFORE RETURNING OR PROCESSING MAY BE DELAYED**