Child/Parent/Guardian Questionnaire

Return To ICBC
PO BOX 2121, STN TERMINAL
VANCOUVER BC V6B 0L6

Fax 1-877-686-4222

The information you provide in this questionnaire will be used, along with medical reports, to assess your child's claim for damages. Please be as accurate as possible. It may be helpful for you to discuss your child's condition with him/her prior to completing the form.

If the form does not provide you with sufficient space, please feel free to attach additional pages or write on the back of this form.

CLAIM NUMBER	EMPLOYEE NAME		EMPLOYEE NUMBER
CHILD'S NAME		DATE OF BIRTH (ddmmmyyyy)	DATE OF LOSS (ddmmmyyyy)

1. Circumstances

Please advise what exactly happened in the accident (Where was your child situated? What was the estimated speed at the time of impact? Was it a two-car collision? etc.) Was the child wearing a seatbelt or similar approved restraint device? Did your child strike any part of his or her body inside the vehicle and, if so, provide details.

2. Injuries

Please describe the injuries your child sustained as a result of this motor vehicle accident.

3. School Missed

Did your child miss school as a result of the accident? If so, how many days were missed? If his or her grades were affected, when did the grades return to normal?

4. Degree of Pain/Suffering

a) In which parts of his/her body did your child experience pain?

b) How frequently did your child have pain?

c) When your child experienced pain, how long did it last?

CLAIM NUMBER	EMPLOYEE NAME	EMPLOYEE NUMBER

4. Degree of Pain/Suffering (continued)

d) Was your child's pain worse at certain times of the day?

e) Did the pain interfere with your child's sleep?

f) Did the pain interfere with your child's ability to engage in physical education, sports or other types of activities? Please describe (e.g. How was your child limited or restricted? Which activities were restricted? etc.)

g) By what date had your child returned to all his/her usual sports and activities? _____
DATE (ddmmmyyyy)

5. Treatment

a) If your child suffered a soft tissue injury, please indicate what treatment your child underwent by ticking the relevant box(s):

- ☐ Medications
- ☐ Chiropractic
- ☐ Heat/ice
- ☐ Massage therapy
- ☐ Rest/refrain activities
- ☐ Acupuncture
- ☐ Home exercises
- ☐ Physiotherapy
- ☐ Other

Please provide the names of your child's treatment provider(s) and indicate the number of appointments attended with each one:

b) If your child suffered another type of injury, please advise what treatment was provided and who provided it.

6. By What Date Was Your Child Recovered? _____
DATE (ddmmmyyyy)

7. Is There Anything Further You Would Like To Add? (For example, how did the injury affect your child's life?)

PARENT/GUARDIAN NAME (please print) | SIGNATURE | DATE (ddmmmyyyy)