

# Child Injury / Incident Report Form

Business or Program Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_



Fill in all blanks and boxes that apply.

Child's Name: \_\_\_\_\_ Gender: M F Birthdate: \_\_\_\_\_ Incident Date: \_\_\_\_\_

Time of Incident: \_\_\_\_:\_\_\_\_ a.m./p.m. Witnesses: \_\_\_\_\_

Name of Parent /Legal Guardian Notified: \_\_\_\_\_ Time Notified: \_\_\_\_:\_\_\_\_ a.m./p.m.  
Notified by (name of staff person): \_\_\_\_\_

Was EMS (911) or other medical professional notified?  No  Yes - Time Notified: \_\_\_\_:\_\_\_\_ a.m./p.m.  
What EMS service(s) responded or other medical professional provided advice?

Location where incident occurred:  Playground  Classroom  Bathroom  Hall  Kitchen  
 Doorway  Gym  Office  Dining Room  Stairway  Motor Vehicle  Unknown  Other (specify)

Equipment/Product involved:  Climber  Playground Surface  Motor Vehicle  Sandbox  Slide  Swing  
 Tricycle/Bike  Toy (specify): \_\_\_\_\_  Other Equipment (specify): \_\_\_\_\_  
 No equipment/product involved

\*Child care provider reported to the Consumer Product Safety Commission the equipment/product involved in the injury.

Yes  No **CPSC Telephone: 1-800-638-2772 CPSC website: <http://www.cpsc.gov/>**

### Cause of Injury / Incident:

- Fall to surface: Estimated height of fall \_\_\_\_feet. Type of surface: \_\_\_\_\_
- Fall from running or tripping  Bitten by child  Motor vehicle  Hit or pushed by another child
- Injured by object  Eating / choking  Bee sting/ spider or tick bite  Animal involved  Exposed to cold or heat
- Child behavior related (specify): \_\_\_\_\_
- Other (specify): \_\_\_\_\_

Describe Injury / Incident: *Include the part(s) of body injured and the type of injury markings.*

First aid / treatment given on-site: (examples: cold pack, comfort, wound cleaning, bandage applied, behavior intervention):

First aid / treatment given by (name of person): \_\_\_\_\_

### Medical / Dental Care Needed Day of Injury / Incident:

- No doctor's or dentist's treatment required  Doctor or dentist office visit same day required
- Treated as an outpatient in emergency room  Hospitalized

Signature of Staff Member: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent / Person Authorized by Parent: \_\_\_\_\_ Date: \_\_\_\_\_

Complete this section with details obtained in days following event. Date of Late Entry: \_\_\_\_\_  
Follow-up treatment needed: \_\_\_\_\_  
Reduced or Limited activity required for \_\_\_\_\_ days.  
Corrective action needed to prevent reoccurrence:  
Signature of person making late entry: \_\_\_\_\_

American Academy of Pediatrics, Pennsylvania Chapter. *Model Child Care Health Policies*. 4<sup>th</sup> ed. Washington D.C: National Association for the Education of Young Children, 2002. Adapted for use by the Iowa Department of Human Services.  
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