Child Care Injury / Incident Report

Child Care Program:	License #:

Name of Injured Child	Age of Child D.O.B. __/__/___	Child's Gender ☐ Male ☐ Female

Date of Incident	Time of Incident ☐ am ☐ pm	☐ Called 911 ☐ Called Poison Control

CHECK ALL THAT APPLY

Type of Injury / Incident

- ☐ Open Wound / Cut
- ☐ Sprain/Strain/Twist
- ☐ Broken Bone / Fracture *
- ☐ Respiratory Condition
- ☐ Pain/Inflammation/Bump
- ☐ Allergy/Sensitivity Reaction
- ☐ Loss of Consciousness*
- ☐ Other:
- ☐ Dislocation *
- ☐ Burn *
- ☐ Poisoning
- ☐ Seizure
- ☐ Concussion*
- ☐ Death *

Body Parts Affected

- ☐ Head/Face
- ☐ Ears
- ☐ Eyes
- ☐ Nose
- ☐ Mouth/Teeth
- ☐ Toes
- ☐ Legs/Knees
- ☐ None
- ☐ Other:
- ☐ Arms/Elbows
- ☐ Hands/Wrists
- ☐ Fingers
- ☐ Abdomen
- ☐ Hip/Pelvis
- ☐ Chest/Shoulders
- ☐ Feet/Ankles
- ☐ Groin
- ☐ Buttocks
- ☐ Torso/Side
- ☐ Neck
- ☐ Back

Side of Body Affected ☐ Left ☐ Right

Professional Medical Treatment Given*

- ☐ First Aid
- ☐ CPR
- ☐ X-rays
- ☐ Stitches / Staples / Glue
- ☐ Dental
- ☐ EMT Treatment On-site
- ☐ Hospitalization
- ☐ Onsite First Aid given (Describe):

Where Injury / Incident Occurred

- ☐ Classroom
- ☐ Child Care Space
- ☐ Kitchen
- ☐ Bathroom
- ☐ Common Areas
- ☐ Outside
- ☐ Off the premises
- ☐ In a vehicle

Cause of Injury / Incident

- ☐ Slip or Trip
- ☐ Struck by Object
- ☐ Overexertion
- ☐ Fall
- ☐ Bites/Scratches/Kicks
- ☐ None/Unknown
- ☐ Fire
- ☐ Electricity
- ☐ Chemicals
- ☐ Structures/Surfaces
- ☐ Other:_____

Taken to Clinic / Hospital

- ☐ By Parent
- ☐ By Provider
- ☐ By Ambulance
- ☐ Unknown
- ☐ Not Taken

I have reviewed the above injury report and certify it is true and accurate to the best of my knowledge: *

_____ Print name, date, and initial

_____ Print name, date, and initial

*include all witnesses to incident

Please give a brief summary of incident:

Describe onsite First Aid given:
_____
_____
_____
_____
_____
_____
By whom:

Parent/Guardian Contacted: _____

By whom (program staff): _____

- ☐ In Person
- ☐ Phone
- ☐ E-mail

Date:_____

Time:_____

Child Care Licensing Contacted (contact for all deaths and any injuries or medical treatment marked with a *)

Who contacted: _____

- ☐ In Person
- ☐ Phone/Fax
- ☐ E-mail

Date:_____

Time:_____

_____
Parent / Guardian Signature Date

_____
Director or Provider Signature Date

Print Name:

Print Name: