

INCIDENT REPORT FORM

THIS FORM IS TO BE FILLED OUT FOR ALL INJURIES
 ANYTIME A CHILD RECEIVES MEDICAL ATTENTION AS A RESULT OF AN INCIDENT OCCURRING AT A CHILD CARE FACILITY,
 THIS FORM MUST BE SUBMITTED TO YOUR CHILD CARE CONSULTANT WITHIN 7 CALENDAR DAYS



Facility Name: _____		Facility ID # <input type="checkbox"/> FCCH <input type="checkbox"/> Center
Name of Injured Child: _____		Age of Child: _____
Child Care Consultant: _____		
Date of Incident: _____	Time of Incident: _____	County: _____

CHECK / CIRCLE ALL THAT APPLY

Type of Injury: <input type="checkbox"/> Allergic Reaction <input type="checkbox"/> Bite <input type="checkbox"/> Broken Bone / Fracture <input type="checkbox"/> Burn -1 st / 2 nd / 3 rd <input type="checkbox"/> Concussion / Bump <input type="checkbox"/> Deep Cut / Scrape <input type="checkbox"/> Dental Injury <input type="checkbox"/> Dislocation / Nurse Maid <input type="checkbox"/> Medication Given in Error <input type="checkbox"/> Sprain / Strain <input type="checkbox"/> Unconsciousness <input type="checkbox"/> Other: _____	Body Part Injured: <input type="checkbox"/> Abdomen / Chest <input type="checkbox"/> Arm / Elbow / Collarbone <input type="checkbox"/> Eye / Eyebrow <input type="checkbox"/> Face / Nose / Chin <input type="checkbox"/> Head / Ear / Forehead <input type="checkbox"/> Foot / Ankle <input type="checkbox"/> Hand / Wrist / Finger <input type="checkbox"/> Leg / Knee <input type="checkbox"/> Mouth / Teeth <input type="checkbox"/> Neck <input type="checkbox"/> Other: _____	Medical Treatment Received: <input type="checkbox"/> CPR <input type="checkbox"/> EMT Treatment Onsite <input type="checkbox"/> First Aid Onsite <input type="checkbox"/> Offsite Medical Treatment <input type="checkbox"/> Stitches / Staples / Glue <input type="checkbox"/> Cast / Brace <input type="checkbox"/> X-rays <input type="checkbox"/> Other: _____	(Cont.) Medical Treatment Received: <input type="checkbox"/> Called 911 <input type="checkbox"/> Called Poison Control <input type="checkbox"/> Fatality <input type="checkbox"/> Hospital Admission <input type="checkbox"/> Medical Treatment Name of Medical Facility: _____ Witnesses to the Incident: _____ _____
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Piece of Equipment Involved: <table style="width: 100%;"> <tr> <td style="vertical-align: top;"> Indoor: <input type="checkbox"/> Block <input type="checkbox"/> Cubby <input type="checkbox"/> Door <input type="checkbox"/> Floor <input type="checkbox"/> Furniture <input type="checkbox"/> Medication <input type="checkbox"/> Other: _____ </td> <td style="vertical-align: top;"> <input type="checkbox"/> Shelving <input type="checkbox"/> Sink <input type="checkbox"/> Steps <input type="checkbox"/> Toy <input type="checkbox"/> Walker <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____ </td> <td style="vertical-align: top;"> Outdoor: <input type="checkbox"/> Bench <input type="checkbox"/> Climber <input type="checkbox"/> Deck <input type="checkbox"/> Fence / Wall <input type="checkbox"/> Rock Wall <input type="checkbox"/> Other Child <input type="checkbox"/> Other: _____ </td> <td style="vertical-align: top;"> <input type="checkbox"/> Play Structure <input type="checkbox"/> Sandbox <input type="checkbox"/> Sidewalk <input type="checkbox"/> Slide <input type="checkbox"/> Surfacing <input type="checkbox"/> Swing <input type="checkbox"/> Vehicle <input type="checkbox"/> Toy <input type="checkbox"/> Other: _____ </td> </tr> </table>	Indoor: <input type="checkbox"/> Block <input type="checkbox"/> Cubby <input type="checkbox"/> Door <input type="checkbox"/> Floor <input type="checkbox"/> Furniture <input type="checkbox"/> Medication <input type="checkbox"/> Other: _____	<input type="checkbox"/> Shelving <input type="checkbox"/> Sink <input type="checkbox"/> Steps <input type="checkbox"/> Toy <input type="checkbox"/> Walker <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____	Outdoor: <input type="checkbox"/> Bench <input type="checkbox"/> Climber <input type="checkbox"/> Deck <input type="checkbox"/> Fence / Wall <input type="checkbox"/> Rock Wall <input type="checkbox"/> Other Child <input type="checkbox"/> Other: _____	<input type="checkbox"/> Play Structure <input type="checkbox"/> Sandbox <input type="checkbox"/> Sidewalk <input type="checkbox"/> Slide <input type="checkbox"/> Surfacing <input type="checkbox"/> Swing <input type="checkbox"/> Vehicle <input type="checkbox"/> Toy <input type="checkbox"/> Other: _____	Location of Incident: _____ Cause of Injury: <input type="checkbox"/> Bite <input type="checkbox"/> Burn <input type="checkbox"/> Chemicals <input type="checkbox"/> Fall From Height <input type="checkbox"/> Pinched / Caught In <input type="checkbox"/> Seizure <input type="checkbox"/> Ran Into Each Other <input type="checkbox"/> Other: _____ <input type="checkbox"/> Slipped / Tripped <input type="checkbox"/> Sharp / Piercing Object <input type="checkbox"/> Splinter / Foreign Object <input type="checkbox"/> Struck by Object <input type="checkbox"/> Swallowed Object <input type="checkbox"/> Bumped Into Object <input type="checkbox"/> Other Child
Indoor: <input type="checkbox"/> Block <input type="checkbox"/> Cubby <input type="checkbox"/> Door <input type="checkbox"/> Floor <input type="checkbox"/> Furniture <input type="checkbox"/> Medication <input type="checkbox"/> Other: _____	<input type="checkbox"/> Shelving <input type="checkbox"/> Sink <input type="checkbox"/> Steps <input type="checkbox"/> Toy <input type="checkbox"/> Walker <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____	Outdoor: <input type="checkbox"/> Bench <input type="checkbox"/> Climber <input type="checkbox"/> Deck <input type="checkbox"/> Fence / Wall <input type="checkbox"/> Rock Wall <input type="checkbox"/> Other Child <input type="checkbox"/> Other: _____	<input type="checkbox"/> Play Structure <input type="checkbox"/> Sandbox <input type="checkbox"/> Sidewalk <input type="checkbox"/> Slide <input type="checkbox"/> Surfacing <input type="checkbox"/> Swing <input type="checkbox"/> Vehicle <input type="checkbox"/> Toy <input type="checkbox"/> Other: _____		

Brief summary of the incident (where & how did the incident occur) & first aid given: _____

Steps to prevent reoccurrence: _____

Parent / Guardian Name: _____	Form completed by: _____
Parent / Guardian Signature: _____	Contacted: <input type="checkbox"/> In Person <input type="checkbox"/> Phone <input type="checkbox"/> Email <input type="checkbox"/> Text <input type="checkbox"/> Phone App
Date: _____	Date & Time Contacted: _____ By Whom: _____
Signature: _____	
Parent's initial in box if your signature also indicates you declined receiving a copy: <input type="checkbox"/> (applicable to centers only)	

If medical treatment is required:
 Original to Child's File
 Copy to Child Care Consultant
 Add to Incident Log

Incident Number: _____	FOR DCDEE USE ONLY
Date Keyed: _____	
Initials: _____	