

SAMPLE

INCIDENT REPORT FORM

Family Child Care Home Child Care Center County Name _____
 Date/Time of Incident _____ Child's Name _____ Sex _____ Age _____
 Witness to Incident _____ Parents Notified By _____ Time Notified _____

Piece of Equipment Involved:

Indoors:	<input type="checkbox"/> Block	<input type="checkbox"/> Furniture	Outdoors:	<input type="checkbox"/> Bench	<input type="checkbox"/> Climber	<input type="checkbox"/> Fence/Wall
<input type="checkbox"/> Cubby	<input type="checkbox"/> Door	<input type="checkbox"/> Floor	<input type="checkbox"/> Composite Play Structure	<input type="checkbox"/> Deck	<input type="checkbox"/> Swing	
<input type="checkbox"/> Medication	<input type="checkbox"/> Toy	<input type="checkbox"/> Other Child	<input type="checkbox"/> Other Child	<input type="checkbox"/> Sandbox	<input type="checkbox"/> Sidewalk	
<input type="checkbox"/> Shelving	<input type="checkbox"/> Sink	<input type="checkbox"/> Walker	<input type="checkbox"/> Slide	<input type="checkbox"/> Surfacing	<input type="checkbox"/> Merry-Go Round	
<input type="checkbox"/> Steps	<input type="checkbox"/> None		<input type="checkbox"/> Toy	<input type="checkbox"/> Other Plygrnd Eqpmnt. _____		
<input type="checkbox"/> Other: _____			<input type="checkbox"/> Vehicle	<input type="checkbox"/> None	<input type="checkbox"/> Other: _____	

Cause of Injury:

Fall from Height Hit By or Bumped Into Object Human Bite Sharp/Piercing Object
 Burn Splinter/Foreign Object Pinched/Caught In Other: _____

Type of Injury:

Dental Injury Cut/Scrape Puncture Bite Bump/Bruise Splinter
 Burn Crush Fracture/Dislocation Sprain/Strain Other: _____

Body Part Injured:

Head Eye Face Mouth Neck Arm Hand/Wrist/Finger Leg
 Abdomen/Trunk/Chest Knee Foot/Ankle Other: _____

Where Child Received Treatment:

Clinic Dentist Doctor's Office Hospital/ER Onsite By Health Professional
 Urgent Care Other: _____

Description of How and Where Incident Occurred & First Aid Received: _____

Steps Taken to Prevent Reoccurrence _____

Signature of Staff Member _____ Date _____

Signature of Parent/Guardian _____ Date _____

**Anytime a Child Receives Medical Treatment as a Result of an Incident Occurring
 at a Child Care Facility this Report Must be Submitted Within
 7 Calendar Days to your Child Care Consultant**

Original to Child's File
Copy to Child Care Consultant
Enter into Incident Log

Child Care Consultant's Name _____

DCD-0058 11/98