



Incident Report Form

Fill in all blanks and boxes that apply.

Name of Program: _____ Phone: _____

Address of Facility: _____

Child's Name: _____ Sex: M F Birthdate: ___/___/___ Incident Date: ___/___/___

Time of Incident: ___:___ am/pm Witnesses: _____

Name of Legal Guardian/Parent Notified: _____ Notified by: _____ Time Notified: ___:___ am/pm

EMS (911) or other medical professional Not notified Notified Time Notified: ___:___ am/pm

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

Equipment / Product involved: Climber Slide Swing Playground Surface Sandbox
 Trike/Bike Handtoy (specify): _____
 Other Equipment (specify): _____

Cause of Injury (describe): _____

- 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 child
- Injured by object Eating or choking Insect sting/bite Animal bite Exposure to cold
- Other (specify): _____

Parts of body injured: Eye Ear Nose Mouth Tooth Part of face Part of head
 Neck Arm/Wrist/Hand Leg/Ankle/Foot Trunk Other (specify): _____

First aid given at the facility (e.g. comfort, pressure, elevation, cold pack, washing, bandage): _____

Treatment provided by: _____

- No doctor's or dentist's treatment required
- Treated as an outpatient (e.g. office or emergency room)
- Hospitalized (overnight) # of days: _____

Number of days of limited activity from this incident: _____ Follow-up plan for care of the child: _____

Corrective action needed to prevent reoccurrence:

Name of Official/Agency notified: _____

Signature of Staff Member: _____ Date: _____

Signature of Legal Guardian/Parent: _____ Date: _____

Reference: American Academy of Pediatrics, Pennsylvania Chapter. 2002. *Model child care health policies*. 4th ed. Washington, DC: national Association for the Education of Young Children.
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