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: ☐Classroom ☐Dining Room ☐Doorway ☐Gym ☐Hall ☐Kitchen ☐Motor Vehicle ☐Office ☐Playground ☐Restroom ☐Stairway ☐Unknown ☐Other (specify) _____

Equipment/Product involved: (check all that apply) ☐Child-proof container ☐Climber ☐Playground Surface ☐Medication Error ☐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: (check all that apply)
☐Animal related ☐Bite, animal ☐Bite, human ☐Child behavior related ☐Choking ☐Cold/heat over exposure
☐Fall, running, or tripping ☐Fall to surface: Estimated height of fall ___feet. Type of surface: _____
☐Hit or pushed by another child ☐Injured by object ☐Medication error ☐Motor vehicle ☐Sting, insect, bee, spider or tick bite
☐Other (specify): _____

Describe Injury / Incident: *Include the part(s) of body injured and the type of injury markings*. *For medication errors describe medication and exact circumstances of the error.*

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*. 4th ed. Washington D.C: National Association for the Education of Young Children, 2002. Adapted for use by the Iowa Departments of Human Services and Public Health for use by child care businesses.
To order more free copies of this form call 800-369-2229 July 2007.

White page is for parent/guardian. **Yellow page** is to be kept with the child's health record.