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: ________________________________

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