

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: