SAMPLE

FOR DCDEE USE ONLY:
Incident Number:_____
Date Keyed:_____ Initials:____

INCIDENT REPORT FORM

Facility Id#_____Facility ID Name_____
Consultant Name_____Date_____
❑ 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: ☐ Block ☐ Furniture ☐ Cubby ☐ Door ☐ Floor ☐ Medication ☐ Toy ☐ Other Child ☐ Shelving ☐ Sink ☐ Walker ☐ Steps ☐ None ☐ Other:_____

Outdoors: ☐ Bench ☐ Climber ☐Fence/Wall ☐ Composite Play Structure ☐ Deck ☐ Swing ☐ Other Child ☐Sandbox ☐ Sidewalk ☐ Slide ☐ Surfacing ☐ Merry-Go Round ☐ Toy ☐ Other Plygrnd Eqpmnt. _____ ☐ Vehicle ☐ None ☐ 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

DCDEE-0058 08/2014