## INCIDENT REPORT FORM

**Facility Id#**____________________  **Facility ID Name**_____________________________

<table>
<thead>
<tr>
<th>Consultant Name</th>
<th>Date</th>
<th><strong>Family Child Care Home</strong></th>
<th><strong>Child Care Center</strong></th>
<th><strong>County Name</strong></th>
</tr>
</thead>
</table>

---

<table>
<thead>
<tr>
<th><strong>Date/Time of Incident</strong></th>
<th><strong>Child's Name</strong></th>
<th><strong>Sex</strong></th>
<th><strong>Age</strong></th>
</tr>
</thead>
</table>

---

<table>
<thead>
<tr>
<th><strong>Witness to Incident</strong></th>
<th><strong>Parents Notified By</strong></th>
<th><strong>Time Notified</strong></th>
</tr>
</thead>
</table>

---

**Piece of Equipment Involved:**

**Indoors:**
- Block
- Door
- Floor
- Cubby
- 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 Playrnd 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/Bruse
- 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** ____________

---

An 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