## **SAMPLE**

## INCIDENT REPORT FORM

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

Facility Id#	Facility ID Name			
Consultant Name				
☐ Family Child Care Ho	ome 🗖 Child Care	Center County Nam	ne	
Date/Time of Incident	Child's Name		Sex	Age
Witness to Incident	Parents Notified By		Time Notif	ied
Piece of Equipment In				
Indoors: ☐ Block		Outdoors:   Ben		
□ Cubby □ Door	□ Floor	☐ Composite Play St		
☐ Medication ☐ Toy ☐ Shelving ☐ Sink		☐ Other Child ☐ San☐ Slide ☐ Surf		
☐ Steps ☐ None	□ warker	☐ Toy ☐ Othe		
□ Other:		□ Vehicle □ Non	e 🛘 Other:	
	<del>_</del>			
Cause of Injury:				
☐ Fall from Height ☐ H	it By or Bumped Inte	o Object	nan Bite □Sharp/P	iercing Object
_	-	ct □Pinched/Caugh	_	
Type of Injury:				
· ·				
☐ Dental Injury ☐ ☐ ☐ ☐ ☐	_		_	
□ Burn □ Crush □	I Fracture/Dislocation	n □ Sprain/Strain	□ Other:	
Body Part Injured:				
			<b>5</b> 11 1/37 : ./D:	<b>-</b>
☐ Head ☐ Eye ☐			_	_
☐ Abdomen/Trunk/Chest	□ Knee	☐ Foot/Ankle	□ Other	
Where Child Received Treatment:				
□ Clinic □ Dentist □		☐ Hospital/ER ☐ □	Ongita Bu Haalth Dw	ofoggional
☐ Urgent Care ☐		-	Onsite by Health Fr	oiessionai
L'orgent care	Other		_	
Description of How an	nd Where Inciden	t Occurred & First	Aid Received:	
•				
C. T. I D.	4 D			
Steps Taken to Prever	it Keoccurrence _			
Signature of Staff Memb	er		_ Date	
Signature of Parent/Gua	rdian			
		Prootmont as a Result of		

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

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