Revised 3/2021

INCIDENT REPORT FORM

THIS FORM IS TO BE FILLED OUT FOR ALL INJURIES
ANYTIME A CHILD RECEIVES MEDICAL ATTENTION AS A RESULT OF AN INCIDENT OCCURRING AT A CHILD CARE FACILITY, THIS FORM MUST BE SUBMITTED TO YOUR CHILD CARE CONSULTANT WITHIN 7 CALENDAR DAYS

Facility Name:		Facility ID # ☐ FCCH ☐ Center
Name of Injured Child:	Age of Child:	Child Care Consultant:
Date of Incident:	Time of Incident:	County:

CHECK / CIRCLE ALL THAT APPLY

Type of Injury:
- ☐ Allergic Reaction
- ☐ Bite
- ☐ Broken Bone / Fracture
- ☐ Burn -1st / 2nd / 3rd
- ☐ Concussion / Bump
- ☐ Deep Cut / Scrape
- ☐ Dental Injury
- ☐ Dislocation / Nurse Maid
- ☐ Medication Given in Error
- ☐ Sprain / Strain
- ☐ Unconsciousness
- ☐ Other:

Body Part Injured:
- ☐ Abdomen / Chest
- ☐ Arm / Elbow / Collarbone
- ☐ Eye / Eyebrow
- ☐ Face / Nose / Chin
- ☐ Head / Ear / Forehead
- ☐ Foot / Ankle
- ☐ Hand / Wrist / Finger
- ☐ Leg / Knee
- ☐ Mouth / Teeth
- ☐ Neck
- ☐ Other:

Medical Treatment Received:
- ☐ CPR
- ☐ EMT Treatment Onsite
- ☐ First Aid Onsite
- ☐ Offsite Medical Treatment
- ☐ Stitches / Staples / Glue
- ☐ Cast / Brace
- ☐ X-rays
- ☐ Other:

(Cont.) Medical Treatment Received:
- ☐ Called 911
- ☐ Called Poison Control
- ☐ Fatality
- ☐ Hospital Admission
- ☐ Medical Treatment

Name of Medical Facility: _____

Witnesses to the Incident:
_____
_____

Piece of Equipment Involved:

Indoor:
- ☐ Block
- ☐ Cubby
- ☐ Door
- ☐ Floor
- ☐ Furniture
- ☐ Medication
- ☐ Other:
- ☐ Shelving
- ☐ Sink
- ☐ Steps
- ☐ Toy
- ☐ Walker
- ☐ Unknown

Outdoor:
- ☐ Bench
- ☐ Climber
- ☐ Deck
- ☐ Fence / Wall
- ☐ Rock Wall
- ☐ Other Child
- ☐ Play Structure
- ☐ Sandbox
- ☐ Sidewalk
- ☐ Slide
- ☐ Surfacing
- ☐ Swing
- ☐ Vehicle
- ☐ Toy
- ☐ Other:

Location of Incident: _____

Cause of Injury:
- ☐ Bite
- ☐ Burn
- ☐ Chemicals
- ☐ Fall From Height
- ☐ Pinched / Caught In
- ☐ Seizure
- ☐ Ran Into Each Other
- ☐ Other:
- ☐ Slipped / Tripped
- ☐ Sharp / Piercing Object
- ☐ Splinter / Foreign Object
- ☐ Struck by Object
- ☐ Swallowed Object
- ☐ Bumped Into Object
- ☐ Other Child

Brief summary of the incident (where & how did the incident occur) & first aid given: _____

_____

_____

Steps to prevent reoccurrence: _____

_____

Parent / Guardian Name: _____ **Form completed by:** _____

Parent / Guardian Signature: _____ **Contacted:** ☐ **In Person** ☐ **Phone** ☐ **Email** ☐ **Text** ☐ **Phone App**

Date: _____ **Date & Time Contacted:** _____ **By Whom:** _____

Signature: _____

Parent's initial in box if your signature also indicates you declined receiving a copy: ☐ (applicable to centers only)

If medical treatment is required:
Original to Child's File
Copy to Child Care Consultant
Add to Incident Log

Incident Number: _____
Date Keyed: _____
Initials: _____

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