## INCIDENT REPORT FORM

$\square$ Child Care Home Date/Time of Incident $\qquad$ Child's Name

County Name $\qquad$ Witness to Incident $\qquad$ Parents Notified By $\qquad$ Time Notified Sex Age $\qquad$

Piece of Equipment Involved:


## Cause of Injury:

| $\square$ Fall from Height | $\square$ Hit By or Bumped Into Object |  |  |
| :--- | :--- | :--- | :--- |
| $\square$ Burn | $\square$ Splinter/Foreign Object | $\square$ Human Bite <br> $\square$ Pinched/Caught In | $\square$ Sharp/Piercing Object <br> $\square$ Other: |

## Type of Injury:

| $\square$ Dental Injury |  |
| :--- | :--- |
| $\square$ Burn $\quad \square$ Crush | $\square$ Fracture/Dislocation $\quad \square$ Puncture |$\square$ Bite $\square$ Bump/Braise $\square$ Splinter

## Body Part Injured:

| $\square$ | $\square$ Eye | $\square$ Face | $\square$ Mouth | - Neck | $\square \mathrm{Arm}$ | $\square$ Hand/Wrist/Finger |  | eg |
| :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: |
| $\square$ Abdo | runk/Chest |  | - $\square$ Fo |  | O |  |  |  |


| Where Child Received Treatment: |  |  |
| :--- | :--- | :--- |
| $\square$ Clinic Dentist | $\square$ Doctor's Office Hospital/ER | $\square$ Onsite By Health Professional |
| $\square$ Urgent Care | Other_ |  |

Description of How and Where Incident Occurred \& First Aid Recd.:

## Steps Taken to Prevent Reoccurrence

$\qquad$

Signature of Staff Member $\qquad$ Date $\qquad$
Signature of Parent/Guardian $\qquad$ Date $\qquad$
Anytime a Child Receives Medical Treatment as a Result of an Incident Occurring at a Child Care Center or Child Care Home this Report Must be Submitted Within 7 Calendar Days to your Child Care Consultant \{Rule 10 NCAC 3U .0802(d); 10 NCAC 3U .1717(a)(3)(T)\}

## Original to Child's File

Copy to Child Care Consultant
Copy to Parent/Guardian
Enter into Incident Log
Child Care Consultant's Name

