Incident Report Form

Fill in all blanks and boxes that apply.

Name of Program: ____________________________________________  Phone: ____________________________________________

Address of Facility: ____________________________________________________________________________________________

Child’s Name: ______________________________  Sex: M F   Birthdate: ___/___/___   Incident Date: ___/___/___

Time of Incident: ___:___am/pm   Witnesses: ________________________________________________________________

Name of Legal Guardian/Parent Notified: ___________________________ Notified by: ____________________________ Time Notified: ___:___am/pm

EMS (911) or other medical professional  □Not notified  □Notified   Time Notified: ___:___am/pm

Location where incident occurred:  □Playground   □Classroom   □Bathroom   □Hall   □Kitchen   □Doorway
  □Gym   □Office   □Dining Room   □Stairway   □Unknown   □Other (specify)__________________________

Equipment / Product involved:  □Climber   □Slide   □Swing   □Playground Surface   □Sandbox
  □Trike/Bike   □Handtoy (specify): _________________________________________________________
  □Other Equipment (specify): _________________________________________________________________

Cause of Injury (describe): _______________________________________________________________________________________

□Fall to surface; Estimated height of fall ___feet; Type of surface: ____________________________________________
  □Fall from running or tripping  □Bitten by child   □Motor vehicle   □Hit or pushed by child
  □Injured by object   □Eating or choking   □Insect sting/bite   □Animal bite   □Exposure to cold
  □Other (specify): ________________________________________________________________

Parts of body injured:  □Eye   □Ear   □Nose   □Mouth   □Tooth   □Part of face   □Part of head
  □Neck   □Arm/Wrist/Hand   □Leg/Ankle/Foot   □Trunk   □Other (specify): __________________________

First aid given at the facility (e.g. comfort, pressure, elevation, cold pack, washing, bandage): __________________________

Treatment provided by: _________________________________________________________________

□No doctor’s or dentist’s treatment required
  □Treated as an outpatient (e.g. office or emergency room)
  □Hospitalized (overnight) # of days: _________

Number of days of limited activity from this incident: _________ Follow-up plan for care of the child: __________________________

Corrective action needed to prevent reoccurrence:

Name of Official/Agency notified: _________________________________________________________________

Signature of Staff Member: ____________________________________________ Date: ____________________________

Signature of Legal Guardian/Parent: ____________________________ Date: ____________________________


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