Child Injury / Incident Report Form

Business or Program Name:
Phone Number:
Address:

Fill in all blanks and boxes that apply.

Child’s Name: __________________________ Gender: M  F  Birthdate: __________ Incident Date: __________

Time of Incident: __:__ a.m./p.m. Witnesses: ____________________________________________________________

Name of Parent /Legal Guardian Notified: __________________________ Time Notified: __:__ a.m./p.m.
Notified by (name of staff person): ______________________________ Time Notified: __:__ a.m./p.m.

Was EMS (911) or other medical professional notified?  No  Yes - Time Notified: __:__ a.m./p.m.

What EMS service(s) responded or other medical professional provided advice?

Location where incident occurred:  Classroom  Dining Room  Doorway  Gym  Hall  Kitchen  Motor Vehicle  Office
Playground  Restroom  Stairway  Unknown  Other (specify) ______________________________

Equipment/Product involved:  (check all that apply)  Child-proof container  Climber  Playground Surface  Medication Error
Motor Vehicle  Sandbox  Slide  Swing  Tricycle/Bike  Toy (specify): __________________________
Other Equipment (specify): __________________________

Child care provider reported to the Consumer Product Safety Commission the equipment/product involved in the injury.
Yes  No

CPSC Telephone: 1-800-638-2772  CPSC website: http://www.cpsc.gov/

Cause of Injury / Incident:  (check all that apply)  Animal related  Bite, animal  Bite, human  Child behavior related  Choking  Cold/heat over exposure
Fall, running, or tripping  Fall to surface: Estimated height of fall ______ feet. Type of surface: __________________
Hit or pushed by another child  Injured by object  Medication error  Motor vehicle  Sting, insect, bee, spider or tick bite
Other (specify): ____________________________________________________________

Describe Injury / Incident: Include the part(s) of body injured and the type of injury markings. For medication errors describe medication and exact circumstances of the error.

First aid / treatment given on-site: (examples: cold pack, comfort, wound cleaning, bandage applied, behavior intervention):

First aid / treatment given by (name of person):

Medical / Dental Care Needed Day of Injury / Incident:
No doctor's or dentist's treatment required  Doctor or dentist office visit same day required
Treated as an outpatient in emergency room  Hospitalized

Signature of Staff Member: __________________________ Date: __________________________

Signature of Parent / Person Authorized by Parent: __________________________ Date: __________________________

Complete this section with details obtained in days following event.  Date of Late Entry: ________________
Follow-up treatment needed: ________________________________________________________________
Reduced or Limited activity required for _______ days.
Corrective action needed to prevent reoccurrence:

Signature of person making late entry:

White page is for parent/guardian. Yellow page is to be kept with the child’s health record.