

Appendix CC

Incident Report Form

Fill in all blanks and boxes that apply.

Name of Program: _____ Phone: _____

Address of Facility: _____

Child's Name: _____ Sex: M F Birth Date: ___/___/___ Incident Date: ___/___/___

Time of Incident: ___ : ___ am/pm Witnesses: _____

Name of Parent/Legal Guardian 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 Hand Toy (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 (eg, comfort, pressure, elevation, cold pack, washing, bandage): _____

Treatment Provided by: _____

- No doctor's or dentist's treatment required
- Treated as an outpatient (eg, 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 PARENT/LEGAL GUARDIAN

DATE

Copies: 1) Child's folder. 2) Parent. 3) Injury log file.