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: _____________

Copies: 1) Child’s Folder 2) Parent 3) Injury Log File