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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