

Child Care Injury / Incident Report

Provider Name		Provider ID	
Name of Injured Child		Age of Child	Child's Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Incident	Time of Incident	<input type="checkbox"/> am <input type="checkbox"/> pm	<input type="checkbox"/> Called 911 <input type="checkbox"/> Called Poison Control
CHECK ALL THAT APPLY			
Type of Injury / Incident <input type="checkbox"/> Open Wound / Cut <input type="checkbox"/> Sprain/Strain/Twist <input type="checkbox"/> Broken Bone / Fracture <input type="checkbox"/> Respiratory Condition <input type="checkbox"/> Pain/Inflammation/Bump <input type="checkbox"/> Allergy/Sensitivity Reaction <input type="checkbox"/> Loss of Consciousness <input type="checkbox"/> Other:		Body Parts Affected <input type="checkbox"/> Head/Face <input type="checkbox"/> Ears <input type="checkbox"/> Eyes <input type="checkbox"/> Nose <input type="checkbox"/> Mouth/Teeth <input type="checkbox"/> Toes <input type="checkbox"/> Legs/Knees <input type="checkbox"/> None <input type="checkbox"/> Other:	
<input type="checkbox"/> Dislocation <input type="checkbox"/> Burn <input type="checkbox"/> Poisoning <input type="checkbox"/> Seizure		<input type="checkbox"/> Arms/Elbows <input type="checkbox"/> Hands/Wrists <input type="checkbox"/> Fingers <input type="checkbox"/> Abdomen <input type="checkbox"/> Hip/Pelvis <input type="checkbox"/> Chest/Shoulders <input type="checkbox"/> Feet/Ankles	
<input type="checkbox"/> Hospital Admission (overnight) <input type="checkbox"/> Fatality		Professional Medical Treatment Given <input type="checkbox"/> First Aid <input type="checkbox"/> CPR <input type="checkbox"/> X-rays <input type="checkbox"/> Stitches / Staples / Glue <input type="checkbox"/> Dental <input type="checkbox"/> EMT Treatment Onsite <input type="checkbox"/> Other	
Where Injury / Incident Occurred Indoor <input type="checkbox"/> Classroom/Playroom <input type="checkbox"/> Kitchen <input type="checkbox"/> Bathroom <input type="checkbox"/> Sleeping Area <input type="checkbox"/> Other:		Side of Body Affected <input type="checkbox"/> Left <input type="checkbox"/> Right	
Outdoor <input type="checkbox"/> Play Area <input type="checkbox"/> Playground Equipment <input type="checkbox"/> Pool / Water <input type="checkbox"/> During Field Trip <input type="checkbox"/> Other:		Cause of Injury / Incident <input type="checkbox"/> Slip or Trip <input type="checkbox"/> Struck by Object <input type="checkbox"/> Overexertion <input type="checkbox"/> Fall <input type="checkbox"/> Bites/Scratches/Kicks <input type="checkbox"/> None/Unknown <input type="checkbox"/> Other:	
		Taken to Clinic / Hospital <input type="checkbox"/> By Parent <input type="checkbox"/> By Provider <input type="checkbox"/> By Ambulance <input type="checkbox"/> Unknown <input type="checkbox"/> Not Taken	
List names of staff present and/or witnesses:			
Please give a brief summary of incident.			
Parent/Guardian Contacted <input type="checkbox"/> In Person Date: <input type="checkbox"/> Phone <input type="checkbox"/> E-mail Time:		Licensors Contacted <input type="checkbox"/> In Person Date: <input type="checkbox"/> Phone <input type="checkbox"/> E-mail Time:	
		Social Worker Contacted (if child has a Social Worker) <input type="checkbox"/> In Person Date: <input type="checkbox"/> Phone <input type="checkbox"/> E-mail Time:	
Parent / Guardian Comments:			
_____ Parent / Guardian Signature Date		_____ Licensee/Staff Signature Date	
Print Name:		Print Name:	
For DEL use only: <input type="checkbox"/> Minor <input type="checkbox"/> Serious <input type="checkbox"/> Critical <input type="checkbox"/> Intake <input type="checkbox"/> LCIR			