Early Childhood Services Child Incident Report

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ am/pm Center: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Class: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Nature of Incident (circle) |
| Bite | Bump | Fall | Nosebleed | Scratch |
| Break | Burn | Loose Tooth | Pain | Sting |
| Bruise | Cut | Lost Tooth | Scrape | Swelling |
| Other: |

|  |
| --- |
| Area Affected (circle) |
| HEAD | BODY | UPPER LIMB | LOWER LIMB |
| Cheek | Nose | Abdomen | Groin | Arm | Ankle | Knee |
| Chin | Teeth | Back | Neck | Finger | Hip | Thigh |
| Ear | Tongue | Buttock | Shoulder | Wrist | Leg |  |
| Eye | Forehead | Chest |  | Elbow | Toe |  |
| Head | Mouth |  |  | Hand | Foot |  |
| LEFT or RIGHT | UPPER or LOWER | WHICH FINGER, TOE? |
| Other: |
| Action Taken (circle) |
| Washed with soap and water | Applied cold pack | Mouth rinsed with cold water |
| Band-aid | Applied Pressure | Head injury follow-up form |
| Other: |
| Skin Broken? | Exposure to blood? | Follow-up required? | 911 called? | Professional medical care required? |
| Yes or No | Yes or No | Yes or No | Yes or No | Yes or No |

Where did it happen? (circle) Classroom/Playground/Gross Motor/Field Trip/Stairs/Bus/Hallway

Specific location? How did it happen? Activity child was engaged in?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Name of person notified: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person completing report: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reviewed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Center Manager or Designee/Date Health Team Member/Date

I acknowledge that a CEO staff member reviewed this report with me:

Signature of Parent/Guardian/Authorized Pick-up Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

File original in child’s file Send Copy to Parent (circle): Electronic copy Paper copy