Child Injury / Incident Report Form **HACAP HS/EHS Site:**

Fill in all blanks and boxes that apply.

Child's Name: _____ Gender: M F Birthdate: _____ Incident Date: _____

Time of Incident: ____:____ a.m./p.m. Witnesses: _____

Name of Parent/Legal Guardian Notified: _____ Time Notified: ____:____ a.m./p.m.

Notified by (name of staff person): _____

Was EMS (911) or other medical professional notified? ☐ No ☐ Yes Time Notified: _____:_____a.m./p.m.
What EMS service(s) responded or other medical professional provided Advice?

Location where incident occurred: ☐ Playground ☐ Classroom ☐ Bathroom ☐ Hall ☐ Kitchen ☐ Gym ☐ Doorway ☐ Office
☐ Dining Room ☐ Stairway ☐ Motor Vehicle ☐ Unknown ☐ Other (specify) _____

Equipment/Product involved: ☐ Playground Surface ☐ Climber ☐ Tricycle/Bike ☐ Sandbox ☐ Slide ☐ Swing ☐ Motor vehicle
☐ Toy (specify): _____ ☐ Other (specify): _____
☐ No equipment or product involved

Cause of Injury/Incident: ☐ Fall to Surface: Estimated height of fall _____ feet. Type of surface: _____
☐ Fall from running or tripping ☐ Bitten by child ☐ Hit or pushed by another child ☐ Injured by object ☐ Eating/choking
☐ Bee sting/spider or tick bite ☐ Animal involved ☐ Exposed to cold/heat ☐ Motor vehicle
☐ Child behavior related (specify): _____
☐ Other (specify): _____
Describe Injury/Incident: *Include the part(s) of body injured and the type of injury markings.*

First Aid/Treatment given on-site: *(examples: cold pack, comfort, wound cleaning, bandage applied, behavior intervention):*

First Aid/Treatment given by (name of person): _____

Medical/Dental Care Needed Day of Injury/Incident:
☐ No doctor or dentist treatment required ☐ Doctor or dentist office visit same day required
☐ Treated as an outpatient in emergency room ☐ Hospitalized

Signature of Staff Member: _____ Date: _____

Signature of Parent/ Person Authorized by Parent: _____ Date: _____

Initials of Site Supervisor: _____ Date: _____

Complete this section with details obtained in days following event. Date of Late Entry: _____
Follow-up treatment needed: _____
_____
Reduced or Limited activity required for _____days.
Corrective action needed to prevent reoccurrence:

Signature of person making late entry:

American Academy of Pediatrics Pennsylvania Chapter. *Model Child Care Health Policies*. 4th ed. Washington D.C.: National Association for the Education of Young Children, 2002. Adapted for use by the Iowa Department of Human Services. Adapted for use by Hawkeye Area Community Action Program, inc.
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