

# ACCIDENT/INCIDENT REPORT

Class/Area # \_\_\_\_\_ Date of Incident \_\_\_\_\_ Time of Incident \_\_\_\_\_

Child's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex:  Male  Female

Staff Present/Witness(es) \_\_\_\_\_

Parent's Name(s) \_\_\_\_\_

How was parent contacted:  By phone  By note  In person  Other \_\_\_\_\_

## Description of how and where accident/incident occurred

## Steps taken to prevent reoccurrence

### Environmental Factor(s) Involved N/A

**Indoors:**  Block  Furniture  
 Cubby  Door  Floor  
 Medication  Toy  Other Child  
 Sink  Steps  Adult

Other \_\_\_\_\_

If  ved any above=

Date of last class inspection \_\_\_\_\_

**Outdoors:**  Bench  Climber  
 Fence/Wall  Other Child  Sandbox  
 Sidewalk  Slide  Surfacing  
 Toy  Vehicle  Adult

Other \_\_\_\_\_

If  ved above=

Date of last Playground inspection \_\_\_\_\_

### Injury to self Injury to other(s) **If yes to either, indicate cause of injury**

Fall from height  Slip or trip  Hit by or bumped into object  Burn  Bite/Scratch/Kick  
 Sharp piercing object  Splinter/Foreign Object  Pinched/Caught in  Other \_\_\_\_\_

**Type of Injury** (if applicable)  Dental injury  Cut/Scrape  Puncture  Bite  Crush  Burn  
Bump/Bruise  Splinter  Fracture/Dislocation  Sprain/Strain  Other \_\_\_\_\_

**Body Part Injured** (if applicable)  Head  Eye  Face  Mouth  Neck  Arm  Hand

Wrist  Finger  Abdomen  Trunk/Chest  Leg  Knee  Foot  Ankle  Other \_\_\_\_\_

**Treatment**  N/A if this report does not include an injury to self

Onsite by staff (Name \_\_\_\_\_)  Urgent Care/Clinic  Hospital/ER

Doctor's Office  Dentist  Other \_\_\_\_\_

If applicable describe first aid given by staff  band aid  cold pack  cleaned wound

Other \_\_\_\_\_

Signature of staff member \_\_\_\_\_ Date \_\_\_\_\_

Signature of supervisor \_\_\_\_\_ Date \_\_\_\_\_

## **ACCIDENT/INCIDENT REPORT**

Any accident or injury requiring professional medical care, death or other emergency involving a child shall be reported immediately to the DCFS licensing office, Executive Director and Health Coordinator. See DCFS licensing standards 407.70(m) for further instructions.

\*If medical care was needed, a statement must be obtained from the physician describing the nature and extent of the injury.

\*Attach physician's statement to a copy of the Incident Report form and submit to Central Office.