Accident/Injury Report

Site: | Provider ID:

Person Injured: Child ☐ Staff ☐ Volunteer ☐ Visitor ☐

Name: | Age: | Gender: ☐ Male ☐ Female

Date of Injury/Accident: | Time of Injury/Accident: ☐ am ☐ pm | ☐ Called 911 ☐ Called Poison Control

CHECK ALL THAT APPLY

Type of Injury/Accident

- ☐ Open Wound/Cut
- ☐ Sprain/Strain/Twist
- ☐ Broken Bone/Fracture
- ☐ Respiratory Condition
- ☐ Pain/Inflammation/Bump
- ☐ Allergy/Sensitivity Reaction
- ☐ Loss of Consciousness
- ☐ Dislocation
- ☐ Burn
- ☐ Positioning
- ☐ Seizure
- ☐ Child left unattended
- ☐ Holds/Scoops
- _____**Duration of hold**
- ☐ Safety Care Holds (By trained staff **ONLY**)
- _____**Duration of hold**
- ☐ Other:

Body Parts Affected

☐ Head/Face	☐ Arms/Elbows
☐ Ears	☐ Hands/Wrists
☐ Eyes	☐ Fingers
☐ Nose	☐ Abdomen
☐ Mouth/Teeth	☐ Hip/Pelvis
☐ Toes	☐ Chest/Shoulders
☐ Legs/Knees	☐ Feet/Ankles
☐ Buttocks	☐ Groin
☐ Torso/Side	☐ Neck
☐ Back	☐ None
☐ Other:	

Side of Body Affected:

☐ Left ☐ Right

Professional Medical Treatment Given

- ☐ First Aid
- ☐ CPR
- ☐ X-Rays
- ☐ Stitches/Staples/Glue
- ☐ Dental
- ☐ EMT Treatment Onsite
- ☐ Other:

Taken to Clinic / Hospital

- ☐ By Parent
- ☐ By Provider
- ☐ By Ambulance
- ☐ Unknown
- ☐ Not Taken

Where Injury/Accident Occurred

☐ Classroom	☐ Hallway
☐ Kitchen	☐ Playground
☐ Bathroom	☐ During Field Trip
☐ Sleeping Area	☐ Parking Lot
☐ Play Area	☐ Other:

Cause of Injury/Accident

☐ Slip or Trip	☐ Bites/Scratches/Kicks
☐ Struck by Object	☐ Electricity
☐ Overexertion	☐ Chemicals
☐ Fall	☐ Structures/Surfaces
☐ Fire	☐ None/Unknown
☐ Other:	

List names and phone number of staff present and/or witnesses:

☐ **N/A Parent/Guardian Contacted by:**

____
Staff Name

____
Parent Name

____
Parent Phone

☐ In Person Date:
☐ Phone Time:

Copy of report to parent on date: ______________

☐ **N/A Licensor Contacted by:**

____
Name

☐ In Person Date:
☐ Phone Time:
☐ E-Mail

☐ **N/A Social Worker Contacted by:**

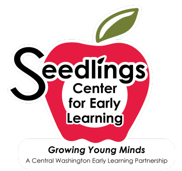
____
Name

☐ In Person Date:
☐ Phone Time:
☐ E-Mail

Parent/Guardian Comments:

Original: Child File Copy: Center Manager Copy: ESD 105 Head Start Director Copy: EPIC Executive Director Copy: Parent

Accident/Injury Report



Please give a detailed, full report of injury or accident:

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Action taken to prevent similar occurrence:

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____ ___________________________
Signatures of staff reporting injury or accident Date

____ ___________________________
Print Name Date

____ ___________________________
Signature of Center Managers Date

____ ___________________________
Print Name Date

Health/Dental/Nutrition #18Revised 3/9/2022