Big Sandy Area C.A.P. Inc.- Head Start

INCIDENT REPORT FORM

Fill in all blanks that apply

Name of program:____Phone:____

Address of facility:____

Child's Name:____Sex: M F Birthday:____/____/____ Incident Date:____/______/_______ ____

Time of incident:___:___ am/pm Witness:______________________________Parent(s) Notified by:_____________Time notified:___:___am/pm

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Location where incident occured: ___ playgroun ___classroom ___bathroom ___hall ___kitchen ___doorway ____ large muscle room or gym

___office ___dining room ____stairway ____ unknown ____ Other (specify)____

Equipment / product involved: ___ climber ___slide ____swing ____playgroun Surface ____sandbox ____ trike /bike ____handtoy ____other

(specify):____

Cause of Injury: (describe):____

___ fall to surface: estimate height of fall _____ feet: type of surface:____

___fall from running or tripping ___ bitten by child ____motor vehicle ___hit or pushed by child ____ injury by object _____ other

___eating of choking ___ insect sting / bite ____animal bite __injury from exposure from cold ___other (specify):__________________

Parts of body injured: ____eye ___ear ___nose ____mouth ____tooth ___other face ____other part of head ____neck ___ arem / wrist hand

___ leg / ankle foot ___ trunk ___ other (specify):____

Type of injury: ___ cut ____bruise or swelling ___puncture ___scrape ___broken bone or dislocation ___ sprain ___crushing injury ___burn

____ loss of consciousness ___unknown ____other (specify):____

First aid given at the facility: (e. g.. pressure, elelvation, cold pack, washing, bandage):____
____

Treatment provided by: ____

_____No doctor's or dentist's treatment required

_____Treated as an outpatient (e.g.. office or emergency room)

_____Hospitalized (overnight) # of days:__________________________

Number of days of limited activity from theis incident:_________ Follow-up plan for care of the child:_____________________________________
____

Corrective action needed to prevent reoccurrence:____

Name of offical / agency notified:____Date___________________

Signature of staff member:____ Date___________________

Signature of parent:____Date___________________