



# INCIDENT REPORT FORM

This form can be used to meet the reporting requirements for accident, injury, illness, hospitalization, emergency room treatment, death or fire.

Name of Facility		Telephone Number
Facility Address		
Name of Child	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date
Child Address		
Name of Parent		Telephone Number
Parent Address		
Parent Notified By		Time Notified <input type="checkbox"/> AM <input type="checkbox"/> PM

## DESCRIPTION OF INCIDENT

Date	Time <input type="checkbox"/> AM <input type="checkbox"/> PM	Location
Equipment/Product/Person Involved	Type of Injury/Incident	Part of Body Injured
Cause of Injury		

## ACTION TAKEN

First-Aid Given By Facility		
Name of Local Authority Notified of Incident		Telephone Number
Address		
Treatment Provided	Telephone Number	Address
Nature of Treatment		
Required Follow-Up		

Signature of Facility Person Completing the Form		Title	Date
<input type="checkbox"/> I request <input type="checkbox"/> Do not request additional Investigation of this incident.			
Signature of Parent		Date	

COMPLETE THE FOLLOWING SECTION ONLY IF THE INCIDENT RESULTED IN PATIENT HOSPITALIZATION, EMERGENCY ROOM TREATMENT, SERVICES OF A FIRE COMPANY, OR THE DEATH OF A CHILD RECEIVING CARE AT THE FACILITY.

NOTIFY REGIONAL DAYCARE OFFICE WITHIN 24 HOURS	Date of Notification	Time of Notification
Name of the Regional Daycare Staff Person Notified		
NOTIFY REGIONAL DAYCARE OFFICE WITHIN 24 HOURS		
Signature of Facility Person Who Made The Notification		Title