Child Injury / Incident Report Form

Fill in all blanks and boxes that apply.

Phone Number:_____

Address:_____

Child's name:_____ Sex: ☐ M ☐ F Birthdate:_____ Incident date:_____

Time of incident:_____:_____ am/pm Witnesses:_____

Name of parent or legal guardian notified:_____ Time notified:_____:_____ am/pm

Notified by (name of staff person):_____

Was EMS (911) or other medical professional notified? ☐ No ☐ Yes Time notified:_____:_____ am/pm

What EMS services responded or other medical professional provided advice?_____

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

Equipment or product involved: ☐ Climber ☐ Slide ☐ Swing ☐ Playground surface
☐ Sandbox ☐ Trike/bike ☐ Hand toy (specify):_____
☐ Motor vehicle ☐ Other equipment (specify):_____

Cause of injury or incident:
☐ Fall to surface; Estimated height of fall _____ feet Type of surface:_____
☐ Fall from running or tripping ☐ Bitten by child ☐ Motor vehicle ☐ Hit or pushed by child
☐ Injured by object ☐ Eating/choking ☐ Bee sting/spider or tick bite ☐ Animal ☐ Exposed to cold or heat
☐ Child behavior related (specify):_____
☐ Other (specify):_____

Describe injury or incident: *Include the parts of the body injured and the type of injury markings*.

First aid or treatment given on-site: *(Examples: cold pack, comfort, wound cleaning, bandage applied, behavior intervention):*

First aid or treatment given by (name of person):_____

Medical or dental care needed day of injury or incident:
☐ No doctor's or dentist's treatment required ☐ Doctor or dentist office visit same day required
☐ Treated as an outpatient in emergency room ☐ Hospitalized

Signature of staff member:_____ Date:_____

Parent signature or authorized pick-up person:_____ 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 January 2004.

Top page is for parent or guardian. Copy is to be kept with the child's health record.

Iowa Child Care Infant, Toddler, Preschool Age – Child Health Exam Form

CHILD INFORMATION Parent complete this page.

Child's name	Child's birthdate
Name of center, provider, or preschool	Telephone number

Parent # 1 name		Parent # 2 name	
Child home address # 1		Child home address # 2	
Home phone # 1	Home email	Home phone # 2	Home email
Where parent # 1 works		Where parent # 2 works	
Work address		Work address	
Work number	Pager number	Work number	Pager number
Cellular number	Work email	Cellular number	Work email

In an emergency, please obtain EMERGENCY MEDICAL or DENTAL CARE if the child care center is unable to contact the parents or guardian. Please contact the following person when a parent or guardian can not be reached.

Name:	***Relationship to child:***	***Phone number:***

Child's doctor's name	Doctor telephone # 1	Hospital choice
Doctor's address	After hours telephone number	Does your child have health insurance? Yes, company_____ **ID #**_____
Child's dentist's name	Dentist telephone # 1	Does your child have dental insurance? Yes, company_____ **ID #**_____
Dentist's Address	After hours telephone number	☐ **NO, we do not have health insurance.** ☐ **NO, we do not have dental insurance.**
Other health care specialist name Type of specialty_____	Telephone number	☐ **Please help us find health or dental insurance.**

Parent Signature	**Date**