Accident/Injury Report

Name of Facility		Address (Street, City, State, Zip)	
Date of Report		Time of Report	
Child Information			
DOB or Age		Gender	☐ Male ☐ Female
Person Reporting		Relationship of Reporter to Facility	
Incident Information			
Date of Incident		Time of Incident	
Witnesses	*Name*: *Address (Street, State, Zip)*: *Phone number:*		
	Name: *Address (Street, State, Zip)*: *Phone number:*		
Nature of the Incident	☐ Death of child while in care ☐ Death of child due to contagious disease (Name of Disease ____________ __________) ☐ Child injury resulting in treatment by medical professional Injury resulting in admission to hospital (Name of Physician or Hospital ______________________ _______) ☐ Injury resulting in death	Location	☐ Classroom ☐ Playground/ Playroom ☐ Bathroom ☐ Kitchen ☐ Basement ☐ Unapproved Area (_________________) ☐ Off-Site Activity (_________________) ☐ Unknown ☐ Other

Cause of Injury	☐ Hit/Cut by Object ☐ Fall from Activity/Equipment (________________) ☐ Fall (Running/Tripping) ☐ Bitten/Scratched by Another Child ☐ Hit/Pushed by Another Child ☐ Eating/Choking ☐ Insect Bite/Sting ☐ Bite from Another Animal ☐ Burn ☐ Heat/Cold Exposure ☐ Other
Incident Details	