

# Injury Report Form

Child's Name (first, last): \_\_\_\_\_

Staff Name: \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_

Time of Incident: \_\_\_:\_\_\_ a.m. or p.m.

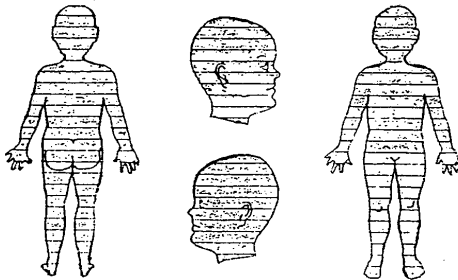
Name of Parent/Guardian notified: \_\_\_\_\_ Time: \_\_\_:\_\_\_ a.m. or p.m.

EMS (911) or other medical professional:  not notified  notified \_\_\_:\_\_\_ a.m. or p.m.

## 1. TYPE OF INJURY

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Scrape/minor cut        | <input type="checkbox"/> Sprain            | <input type="checkbox"/> Foreign object/splinter |
| <input type="checkbox"/> Deep cut/puncture       | <input type="checkbox"/> Burn              | <input type="checkbox"/> Unknown                 |
| <input type="checkbox"/> Bump/bruise             | <input type="checkbox"/> Human bite        | <input type="checkbox"/> Tooth injury            |
| <input type="checkbox"/> Broken bone/dislocation | <input type="checkbox"/> Insect bite/sting | <input type="checkbox"/> Other: _____            |

## 2. BODY PART AFFECTED: \_\_\_\_\_



Description: \_\_\_\_\_

## 3. ACTIVITY AT TIME OF INCIDENT:

- |   |  |                                       |
|---|--|---------------------------------------|
| <input type="checkbox"/> Free play                  | <input type="checkbox"/> Meal/snack      | <input type="checkbox"/> Toileting    |
| <input type="checkbox"/> Circle time/group activity | <input type="checkbox"/> Transition time | <input type="checkbox"/> Other: _____ |

## 4. LOCATION (i.e. playground, bathroom): \_\_\_\_\_

## 5. TREATMENT provided by: \_\_\_\_\_

### Treatment (check all that apply):

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> No treatment         | <input type="checkbox"/> Band aid or dressing | <input type="checkbox"/> Phone call to parent  |
| <input type="checkbox"/> Cleaned injured site | <input type="checkbox"/> Child rested         | <input type="checkbox"/> Referral to physician |
| <input type="checkbox"/> Ice pack applied     | <input type="checkbox"/> Given comfort        | <input type="checkbox"/> Other: _____          |

## 6. CONTRIBUTING FACTORS (check all that apply):

- |  |   |
|--|---|
| <input type="checkbox"/> None                              | <input type="checkbox"/> Fall from(record height): _____      |
| <input type="checkbox"/> Object on floor/ground            | <input type="checkbox"/> Improper use of object/equipment/toy |
| <input type="checkbox"/> Broken/faulty equipment/furniture | <input type="checkbox"/> Pushed/hit/bit by another child      |
| <input type="checkbox"/> Wet/sandy/slippery floor          | <input type="checkbox"/> Object thrown                        |
| <input type="checkbox"/> Window/door/gate                  | <input type="checkbox"/> Other (specify): _____               |

## 7. ADDITIONAL INFORMATION: \_\_\_\_\_

Signature of staff member: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Name of official/agency notified: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_



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### Home Provider Copies:

1) Parent 2) Provider

### Child Care Center Copies

1) Child's folder 2) Parent 3) Injury log