Child Care Injury Report Form

Child's Name:_____ Date of birth ____/____/____ ( )M ( ) F
Parent/GuardianName:_____
Name of Child Care
Program:_____
Parent/Guardian notified by: _____ Time:___:____ a.m./p.m.
Unable to contact parent/guardian: _____Time:___:____a.m./p.m.
Injury Date ____/____/____ Injury Time___:__ a.m./p.m. Fatal ( ) Yes ( ) No
Witnesses:_____
Injury occurred during: ___nap time ___playtime ___lunch time
_____structured activity time _____field trip _____Other: _____

Location where incident occurred: ___playground ___classroom ___restroom
___hall ___doorway ___exercise room ___office ___dining ___stairway
___ wading/swimming pool ___driveway/parking area ___unknown
_____other (specify)_____

Equipment/Products involved: ___climber___slide ___swing ___playground surface
___sandbox ___trike/bike ___hand toy ___other (specify)_____

Contributing Factors: ____run into object or person ____pinch ___contact with fire,
hot object or liquid ___bitten ___insect sting/bite ____animal bite ____hit or pushed by child
____heat exhaustion ___injury from exposure to cold ____hit with thrown object
____fall to surface; estimated height of fall_____ft. ___fall from tripping/slipping

Type of Surface:
____Black top ____carpet ____concrete ____dirt ____gravel ____ice/snow
____lawn/grass ____mats ____sand ___linoleum ____tile ____wood
____other(specify)_____

Parts of Body Injured:
___eye ____ear ____nose ____mouth ____tooth ____other part of head(specify)_____
____neck ___arm ____elbow ____wrist/hand ____finger/thumb ____foot/ankle
____toe ____leg ____knee ____abdomen ___back ____buttocks ____chest/ribs
____shoulder ____pelvis/hips ____genitals
Type of Injury:
___cut ___bruise/swelling ___puncture ___scrape ___broken bone/dislocation
___sprain ___crushing injury ___burn ___sun burn ___loss of consciousness
___drowning/near drowning ___concussion (possible) ___poisoning (specify)_____
other (specify)_____

First Aid given at the facility Yes ( ) No ( ) Staff:_____
Treatment provided by a Health Care Professional
Name:_____
Diagnosis:_____
Hospitalized, number of days_____
No treatment required by Health Care Provider Parents/guardians deem treatment not necessary_____
Number of days of limited activity as directed by a Health Care professional: _____
Follow up plan:
_____
Name of Official/Agency notified_____date_____/_____/____
Signature of Staff Member_____date_____/_____/____

Adapted from Healthy Child Care Florida - Health & Safety Handbook - 2004