Child Care Injury Report Form

Child’s Name: ______________________________ Date of birth ____/____/____ ( )M ( ) F
Parent/Guardian Name: _____________________________________________________________
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