

CONFIDENTIAL

**STUDENT INJURY REPORT
(MEDICAL ATTENTION NEEDED)**

NAME OF CHILD CARE PROGRAM _____ DATE OF INJURY _____

ADDRESS _____ TIME OF INJURY _____

NAME OF CHILD _____ AGE _____ SEX _____

NAME OF PARENT _____

ADDRESS _____

WAS INJURY CAUSED BY A FALL? YES _____ NO _____
IF YES, TYPE OF SURFACE _____

DID INJURY OCCUR ON PLAYGROUND EQUIPMENT? YES _____ NO _____
IF YES, TYPE OF EQUIPMENT _____

HOW DID THE INJURY HAPPEN? (DESCRIBE BRIEFLY) _____

WHERE DID INJURY OCCUR? _____

NAME OF STAFF MEMBER IN CHARGE _____
WAS HE/SHE PRESENT AT SCENE OF INJURY? YES _____ NO _____

WITNESS TO INJURY (IF ANY) _____

WAS CHILD GIVEN FIRST AID? YES _____ NO _____ BY WHOM _____
TYPE OF AID GIVEN? _____

WERE PARENTS NOTIFIED? YES _____ NO _____ BY WHOM _____
WHEN? _____

WAS EMERGENCY TREATMENT PROVIDED AT HOSPITAL/DR. OFFICE/DENTIST? YES _____ NO _____
WHERE? _____

RESULT OF INJURY (DIAGNOSIS/TREATMENT) _____

CORRECTIVE ACTION TAKEN TO PREVENT FURTHER INJURIES _____

SIGNATURE OF DIRECTOR _____ TODAY'S DATE _____

RETURN TO: DIVISION OF FAMILY RESOURCES
BUREAU OF CHILD CARE
402 WEST WASHINGTON STREET, RM W-386
INDIANAPOLIS, IN 46204