



Child Care Injury / Incident Report



To be completed any time an injury that requires first aid or medical care which occurs in a child care home, child development home, or licensed child care facility.

Business or Program Name: _____
Address and Phone Number: _____

Child's Name: _____	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Birthdate: _____
Date and Time of Incident: _____		
Name of Parent/Legal Guardian Notified: _____		
Method of Notification: _____		Time Notified: _____ a.m./p.m.
Notification by (name of staff person): _____		

Serious injuries must be reported to the Department of Human Services within 24 hours of the incident***.

Serious injuries include:

- Disabling mental illness
- Bodily injury which creates a substantial risk of death, causes serious permanent disfigurement, or causes protracted loss or impairment of the function of any bodily member or organ
- Any injury to a child that requires surgical repair and necessitates the administration of general anesthesia
- Includes, but is not limited to, skull fractures, rib fractures, metaphyseal fractures of the long bones of children under the age of 4 years

Did the incident result in a serious injury to a child? Yes No

Did the incident result in death to a child? Yes No

Was EMS (911) or other medical professional notified? Yes No

Time Notified _____ a.m./p.m.

<u>Location where incident occurred:</u>	<input type="checkbox"/> Classroom	<input type="checkbox"/> Dining room	<input type="checkbox"/> Gym	<input type="checkbox"/> Hall
<input type="checkbox"/> Kitchen	<input type="checkbox"/> Motor vehicle	<input type="checkbox"/> Office	<input type="checkbox"/> Playground	<input type="checkbox"/> Restroom
<input type="checkbox"/> Unknown	<input type="checkbox"/> Other (specify): _____			

<u>Equipment/product involved (check all the apply):</u>	<input type="checkbox"/> Climber	<input type="checkbox"/> Motor vehicle
<input type="checkbox"/> Playground surface	<input type="checkbox"/> Sandbox	<input type="checkbox"/> Slide
<input type="checkbox"/> Swing	<input type="checkbox"/> Tricycle/bike/riding toy	
<input type="checkbox"/> Toy (specify): _____	Other equipment (specify): _____	
<input type="checkbox"/> Reported equipment/product involved in the injury to the Consumer Product Safety Commission (CPSC) https://www.cpsc.gov		

If a serious injury or death to a child has occurred in a child care home, child development home, or licensed child care center, please email this incident report form to the Department of Human Services at ccsid@dhs.state.ia.us within 24 hours of the incident.

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Cause of injury/incident (check all the apply):

<input type="checkbox"/> Child bite	<input type="checkbox"/> Choking	<input type="checkbox"/> Cold/heat over exposure	<input type="checkbox"/> Animal bite	<input type="checkbox"/> Child behavior-related
<input type="checkbox"/> Fall to surface: Estimated height of fall _____ feet	<input type="checkbox"/> Fall running/tripping			
<input type="checkbox"/> Hit or pushed by another child	<input type="checkbox"/> Injured by object		<input type="checkbox"/> Medication error	
<input type="checkbox"/> Motor vehicle	<input type="checkbox"/> Poisoning	<input type="checkbox"/> Sting, insect, bee, spider or tick bite		
<input type="checkbox"/> Other (specify): _____				

Describe the injury/incident. Include part(s) of the body injured and the type of injury markings. For medication errors, describe medication, and exact circumstances:

Medical/Dental Care Needed Day of Injury/Incident:

No doctor/dental treatment required

Treated in an outpatient office or emergency room

Hospitalized

What first aid/treatment given on-site?

Who administered first aid or treatment? _____

I have reviewed the above injury report and certify it is true and accurate to the best of my knowledge:

Child Care Provider Signature Date

I have read the above injury report:

Parent/Legal Guardian/Authorized Person Signature Date

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