



### 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:  M  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.

Location where incident occurred:  Classroom  Dining Room  Gym  Hall  
 Kitchen  Motor Vehicle  Office  Playground  Restroom  Stairway  
 Unknown  Other (specify) \_\_\_\_\_

Equipment/Product involved: (check all that apply)  Climber  Motor Vehicle  
 Playground Surface  Sandbox  Slide  Swing  Tricycle/Bike/Riding toy  
 Toy (specify): \_\_\_\_\_ Other Equipment (specify): \_\_\_\_\_  
 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](mailto:ccsid@dhs.state.ia.us) within 24 hours of the incident.\*\*\*

Cause of Injury / Incident( check all that apply)  Animal Bite  Child Behavior-related  Child Bite  Choking  Cold/heat over exposure  Fall running/tripping  Fall to surface: Estimated height of fall \_\_\_feet. Type of surface: \_\_\_\_\_  Hit or pushed by another child  Injured by object  Medication error  Motor vehicle  Poisoning  Sting, insect, bee, spider or tick bite  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 as 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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