Injury Report Form

Fill in all blanks and boxes that apply

Name of Program: ______________________________________________ Phone: _______________________________

Address of Facility: _______________________________________________________________________________________

Child’s Name: ____________________________________ Sex:  M  F  Birthdate:___/___/___  Incident Date:___/___/___

Time of Incident: ______:______ am/pm     Witnesses: ________________________________________________________

Name of Legal Guardian/Parent Notified: ____________ Notified by: ____________ Time Notified: _____:_____ am/pm

EMS (911) or other medical professional  ❏ Not notified ❏ Notified    Time Notified: ______:______ am/pm

Location where incident occurred: ❏ playground ❏ classroom ❏ bathroom ❏ hall ❏ kitchen ❏ doorway ❏ large muscle room or gym ❏ office ❏ dining room ❏ unknown ❏ other (specify) _______________________

Equipment/product involved: ❏ climber ❏ slide ❏ swing ❏ playground surface ❏ sandbox ❏ trike/bike ❏ hand toy (specify):

❏ other equipment (specify): ____________________________________________

Cause of injury: (describe) ________________________________________________________________________________

❏ fall to surface; estimated height of fall _________ feet; type of surface:

❏ fall from running or tripping ❏ bitten by child ❏ motor vehicle ❏ hit or pushed by child ❏ injured by object ❏ eating or choking ❏ insect sting/bite ❏ animal bite ❏ injury from exposure to cold ❏ other (specify): ________

Parts of body injured: ❏ eye ❏ ear ❏ nose ❏ mouth ❏ tooth ❏ other part of face ❏ other part of head ❏ neck ❏ arm/wrist/hand ❏ leg/ankle/foot ❏ trunk ❏ other (specify):

Type of injury: ❏ cut ❏ bruise or swelling ❏ puncture ❏ scrape ❏ broken bone or dislocation ❏ sprain ❏ crushing injury ❏ burn ❏ loss of consciousness ❏ unknown ❏ other (specify):

First aide given at the facility: (e.g., comfort, pressure, elevation, cold pack, washing, bandage): ______________________

Treatment provided by:___________________________________________

❏ no doctor’s or dentist’s treatment required
❏ treated as an outpatient (e.g., office or emergency room)
❏ hospitalized (overnight) # of days: ___________________

Number of days of limited activity from this incident: ________ Follow-up plan for care of the child: ________________

Corrective action needed to prevent reoccurrence: __________________________________________________________

Name of official/agency notified: ____________________________________________ Date:________________________

Signature of staff member: ________________________________________________ Date:________________________

Signature of Legal Guardian/Parent: _________________________________________ Date:________________________

copies: 1) child’s folder  2) parent  3) injury log