

West Virginia Department of Health and Human Resources

Child Care Provider

Incident Report Form

Incidents must be verbally reported within 24 hours. Follow up in writing within 72 hours.

Child Care Provider Information	
Name	
Address	
Phone	

Child Information				
Child's Name				
Birth Date		Gender:	<input type="checkbox"/> Female	<input type="checkbox"/> Male
Name of Legal Guardian/Parent Notified:				
Notified by:		Time Notified	am/pm	

Incident Information			
Date of Incident:		Time of Incident:	am/pm
Witnesses:			
Describe Incident In Detail:			
EMS (911) or other medical professional:			
<input type="checkbox"/> Not Notified	<input type="checkbox"/> Notified	Time:	am/pm
Name of Medical Professional Notified:			
Address:			
Location where incident occurred: (please check all that apply)			
<input type="checkbox"/> Gym	<input type="checkbox"/> Living Room		
<input type="checkbox"/> Dining Room	<input type="checkbox"/> Stairway		
<input type="checkbox"/> Playground	<input type="checkbox"/> Classroom		
<input type="checkbox"/> Bathroom	<input type="checkbox"/> Hall		
<input type="checkbox"/> Kitchen	<input type="checkbox"/> Doorway		
<input type="checkbox"/> Unknown	<input type="checkbox"/> Other:		

Equipment/Product Involved: (please check all that apply)			
<input type="checkbox"/>	Riding Toy (specify) _____	<input type="checkbox"/>	Climber
<input type="checkbox"/>	Slide	<input type="checkbox"/>	Swing
<input type="checkbox"/>	Playground Surface	<input type="checkbox"/>	Sandbox
<input type="checkbox"/>	Hand toy (specify) _____	<input type="checkbox"/>	Other: _____
Cause of Injury: (please check all that apply)			
<input type="checkbox"/>	Fall to Surface	Estimated Height of fall: _____	Type of Surface: _____
<input type="checkbox"/>	Fall from running or tripping	<input type="checkbox"/>	Bitten by child
<input type="checkbox"/>	Motor Vehicle	<input type="checkbox"/>	Hit or pushed by child
<input type="checkbox"/>	Injured by object	<input type="checkbox"/>	Eating or choking
<input type="checkbox"/>	Insect sting or bite	<input type="checkbox"/>	Animal bite
<input type="checkbox"/>	Exposure to cold	<input type="checkbox"/>	Other: _____
Parts of Body Injured: (please check all that apply)			
<input type="checkbox"/>	Eye	<input type="checkbox"/>	Ear
<input type="checkbox"/>	Nose	<input type="checkbox"/>	Mouth
<input type="checkbox"/>	Tooth	<input type="checkbox"/>	Part of Face
<input type="checkbox"/>	Part of Head	<input type="checkbox"/>	Neck
<input type="checkbox"/>	Arm/Wrist/Hand	<input type="checkbox"/>	Leg/Ankle/Foot
<input type="checkbox"/>	Trunk	<input type="checkbox"/>	Other: _____
Describe the First Aid given at the child care:			
Treatment Provided by:			
<input type="checkbox"/>	No doctor's or dentist's treatment required		
<input type="checkbox"/>	Treated as an outpatient (e.g. office or emergency room)		
<input type="checkbox"/>	Hospitalized overnight for _____ # of days		
Number of Days of Limited Activity from This Incident:			
Follow-up plan for care of the child:			
Name of Agency Official Notified:			
Date Notified		Time Notified	am/pm

Signature of Caregiver in Charge of Care

Date

Signature of Legal Guardian/Parent

Date