

CHILD ACCIDENT OR UNUSUAL INCIDENT REPORT

Provider:	Date:
Phone:	Time:
Completed By:	Title:
Check Type of Facility: <input type="checkbox"/> FCCH <input type="checkbox"/> LFCCH <input type="checkbox"/> Center <input type="checkbox"/> School-Age Program	

Names (First, Last) of Participants Involved in the Incident	AGE	SEX	TYPE (Teacher/Child/Parent)

Type of Accident/ Incident:
Describe the accident or incident:

If this was a child abuse incident, was the Child Abuse Hotline notified?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If YES, enter the Registry Counselor's name: If NO, explain:	ID Number:	

Were medical services required?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If YES, describe the treatment and outcome:		

Was the incident handled appropriately?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If NO, explain how the incident could be handled more appropriately:		

Was the parent/guardian notified immediately?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If NO, explain:		

Was the parent/guardian satisfied with the way the incident was handled?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If NO, explain:		

Is a change in procedure necessary to prevent a reoccurrence?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If YES, explain how you intend to prevent a reoccurrence:		

Was disciplinary action necessary?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If YES, describe the disciplinary action that was taken:		

Was legal action necessary?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If YES, describe what legal action was taken:		

Could there be any negative consequences resulting from this incident?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If YES, explain:		