



Incident and Illness Report

Class/Center:		<input type="checkbox"/> Incident <input type="checkbox"/> Illness	
Name of Injured/Ill Child:		Age of Child:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Incident/Illness:	Time of Incident/Illness:	<input type="checkbox"/> Called Poison Control <input type="checkbox"/> Called 911 <input type="checkbox"/> Contacted Parent	Taken to Clinic/Hospital: <input type="checkbox"/> By Parent <input type="checkbox"/> By Ambulance <input type="checkbox"/> Not Taken
Type of Injury/Incident		Body Parts Affected	
<input type="checkbox"/> Scratch <input type="checkbox"/> Open Wound /Cut <input type="checkbox"/> Sprain/Strain/Twist <input type="checkbox"/> Pain/Inflammation/Bump <input type="checkbox"/> Respiratory Condition <input type="checkbox"/> Allergy/Sensitivity Reaction <input type="checkbox"/> Broken Bone /Fracture	<input type="checkbox"/> Loss of Consciousness <input type="checkbox"/> Dislocation <input type="checkbox"/> Burn <input type="checkbox"/> Poisoning <input type="checkbox"/> Seizure <input type="checkbox"/> Other:	<input type="checkbox"/> Head/Face <input type="checkbox"/> Ears <input type="checkbox"/> Eyes <input type="checkbox"/> Nose <input type="checkbox"/> Mouth/Teeth <input type="checkbox"/> Toes <input type="checkbox"/> Legs/Knees <input type="checkbox"/> None <input type="checkbox"/> Other: <input type="checkbox"/> Arms/Elbows	<input type="checkbox"/> Hands/Wrist <input type="checkbox"/> Fingers <input type="checkbox"/> Abdomen <input type="checkbox"/> Hip/Pelvis <input type="checkbox"/> Chest/Shoulders <input type="checkbox"/> Feet/Ankles <input type="checkbox"/> Groin <input type="checkbox"/> Buttocks <input type="checkbox"/> Torso/Side <input type="checkbox"/> Neck <input type="checkbox"/> Back
Where Injury/Incident Occurred		Cause of Injury/ Incident	
<input type="checkbox"/> Art Center <input type="checkbox"/> Bathroom <input type="checkbox"/> Discovery/Science Center <input type="checkbox"/> Dramatic Play <input type="checkbox"/> Library Center <input type="checkbox"/> Listening Center	<input type="checkbox"/> Sensory Center <input type="checkbox"/> Toys/Games Center <input type="checkbox"/> Writing Center <input type="checkbox"/> Playground <input type="checkbox"/> Other:	<input type="checkbox"/> Slip or Trip <input type="checkbox"/> Struck by Object <input type="checkbox"/> Overexertion <input type="checkbox"/> Fall <input type="checkbox"/> Bite/Scratch/Kick <input type="checkbox"/> None/Unknown <input type="checkbox"/> Other:	<input type="checkbox"/> Fire <input type="checkbox"/> Electricity <input type="checkbox"/> Chemicals <input type="checkbox"/> Structures/Surfaces
Side of Body Affected: <input type="checkbox"/> Left <input type="checkbox"/> Right	First Aid Given:		
List names of staff present and/or witnesses:			
Please give a brief summary of incident/illness:			
Parent/Guardian Contacted:			
<input type="checkbox"/> In Person <input type="checkbox"/> Phone <input type="checkbox"/> E-mail		Date: _____ Time: _____	
Parent/Guardian Signature: _____	Date: _____	Staff Signature: _____	Date: _____