

NWCA Head Start Incident Report Form

Fill in all blanks and boxes that apply.

Site: _____ Teacher: _____

Child's Name: _____ Incident Date: ____/____/____

Time of Incident: ____:____ am pm Witnesses: _____

Name of legal Guardian/Parent Notified: _____ Time Notified: ____:____ am pm

Notified by: _____ Method Notified: In-Person Phone Call Text message/email

Parent/Guardian response to notification: _____

Location where incident occurred: Playground Classroom Bathroom Hall Cafeteria Doorway
 Gym Office Dining Room Stairway Unknown Other _____

Equipment/Product Involved: Climber Slide Swing Playground Surface Sandbox Trike/Bike
 Handtoy (specify): _____ Other _____

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 Exposure to cold Other _____

Parts of body injured: Eye (Left Right) Ear (Left Right) Nose Mouth Tooth Part of face
 Part of head Neck Arm/Wrist/Hand (Left Right) Leg/Ankle/Foot (Left Right) Trunk
 Other _____

First aid given: (e.g. comfort, pressure, elevation, cold pack, washing, bandage): _____

Staff providing treatment: _____

No doctor's or dentist's treatment required
 Treated as an outpatient (e.g. office or emergency room)
 Hospitalized (overnight) # of days: _____

*****Office Use Only*****

Corrective action needed to prevent reoccurrence: _____

Additional comments _____

Signature of Staff Member _____ Date: _____