



This form meets Ohio Administrative Code. Programs may use this form or build their own.

Section I - Program Information

Program Name, Program Address, Program License Number, City, County, Zip, First & Last Name of Person Completing Form

Section II - Incident/Injury Report Details

At the time of the incident/injury/illness:

First & Last Name of Child, Names of staff witness/es, Who provided first aid?, How many staff members were supervising this group?, How many children were there in this child's group?, Date of incident/injury/illness, Time of incident/injury/illness, Date of birth, Child's gender, Date of first aid, Family Contacted?, Date family were contacted?

Age of child-group that child was assigned to at the time of the incident/injury/illness: Young Infant, Infant, Toddler, Preschooler, School Age. Number of hours child in your care per day? Full-time, Part-time

Type of Injury (check all that apply)

- Bit cheek/lip/tongue, Nosebleed, Bite human, Object inserted in body part, Bite animal/insect, Poisoning, Blow to head, Puncture wound, Broken bone, Scrape/scratch, Bump/Bruise, Something in eye, Burn, Stubbed finger/toe, Choking, Sunburn, Cut, Swelling/Redness, Difficulty breathing, Tooth chipped/knocked out, Other

Type of Illness (check all that apply)

- Allergic Reaction, Asthma, Collapse/Faint, Diaper Rash, Fever, No Pulse/Breathing, Seizure, Stomachache/Vomiting/Diarrhea, Other (specify in summary)

Type of Incident (check all that apply)

- Another Adult Found Child, Baby Fed Wrong Bottle, Blood/Bruise Found on Child, Child Ran Away, Sudden Diaper Rash, Child Unattended, Collision with Object, Collision with Person, Intruder, Other (specify in summary), Fall - walk/run/trip, Fall to Surface, Fighting, Vehicle Accident

Action Taken (check all that apply)

- Bandage, Ice, Body Part Elevated, Pressure Applied, Called Children's Protective Services, Referred for Further Medical Care, Called Poison Control, Rested on Cot, Called Emergency Services, Returned to Normal Activities, Emergency Services Transported Child, Sent Home Early/Picked Up Early, Hug/Pat, Washed/Soap

Incident Happened Where? (check all that apply)

- Bathroom, Kitchen/Eating Area, Changing Table, On Field Trip/Routine Trip, Classroom, Outdoor Play Area, Hall/Doorway, Parking Area/Driveway, High Chair, Pool, In Vehicle, Stairway, Inside Play Area/Large Muscle Area, Between Activities

Body Part Affected (check all that apply)

- Arm, Foot, Mouth/Teeth, Back, Front of Trunk/Stomach, Neck, Chin, Genitals/Buttocks, Nose, Ear, Hand, Shoulder/Collarbone, Eye, Head, Throat, Face, Leg, Toe, Finger, Lungs/Difficulty breathing, Whole Body

Incident Happened During? (check all that apply)

- Arrival/Departure, Classroom Activity, Diaper Change, Indoor Play/Group Activity/Free Play, Meals/Snacks, Outdoor Play, Nap time/Rest Period

Summary of Incident

If Needed, Attach Additional Documentation

Signature of Person Completing Form, Date