Elkhart and St. Joseph Counties Head Start Consortium
ACCIDENT/INCIDENT REPORT FORM

Please Circle: Staff or Child Information

First Name: _____

Last Name: _____

Gender: ☐ Female ☐ Male Age:_____

DOB:_____/_____/_____ Time: _____

Address: _____

City:_____State:_____

Zip: _____ Telephone:_____

Classroom/Bus Information

Site: _____

Session: _____

Lead Teacher:_____

Was Teacher Present? Yes ☐ No ☐

Bus Drive Name: _____ Bus #_____

Date:_____ Time: _____

Parent/Guardian Notified (Name): Time: How: By Whom:

_____ _____ _____ _____

Location

Circle one:
Classroom Gym Hallway Bathroom Playground Sidewalk Bus Other:_____

Description of Incident

How did it happen, who, what, when, where, and why? _____

_____

Describe injury or behavior: _____

Choking/Seizure/How long did seizure last: _____

Observed (check box): ☐ Eyes Rolled Back ☐ Body Convulsions ☐ Blank Stare ☐ Other:_____

Action taken by (Name): _____

Sent to: ☐ Nurse ☐ Home ☐ Physician ☐ Hospital ☐ None

First Aid Administered (Describe): _____

Action Taken: _____

Was follow up required? If yes explain: _____

_____

Within 24 hours of incident, contact Child Services if:

- Any injuries requiring treatment by a physician, dentist, or use of an emergency vehicle.
- If a child is missing or the death of a child while in the care of Head Start Staff.
- The occurrence of a fire requiring service of the fire department or notification of police.

_____	_____	_____	_____
Person Reporting Incident	Date	Head Start Manager	Date
_____	_____	_____	_____
Head Start Site Supervisor	Date	Head Start Executive Director	Date
_____	_____	_____	_____
Transportation Director/Designee	Date	Head Start Health Manager	Date

White: Email grantee office, child's file Yellow: Appropriate Head Start Manager Pink: Parent