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.

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|---|---|---|---|
| _____ | _____ | _____ | _____ |
| Person Reporting Incident | Date | Head Start HR Manager | Date |
| _____ | _____ | _____ | _____ |
| Head Start Program Manager | Date | Head Start Executive Director | Date |
| _____ | _____ | _____ | _____ |
| Transportation Manager/Designee | Date | Head Start Health Manager | Date |

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