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

**Please Circle: Staff or Child Information**

First Name: _____

Last Name: _____

Gender: ☐ Female ☐ Male Age: _____

DOB: _____/_____/_____

Address: _____

City: _____ State: _____

Zip: _____ Telephone: _____

**Classroom/Bus Information**

Site:(Mandatory) _____

Session: _____

Lead Teacher: _____

Was Teacher Present? Yes ☐ No ☐

Bus Driver Name: _____

Bus # _____ Licensing: _____

Date Report filed to Federal Office: (**Office Use Only**) _____

| Parent/Guardian Notified | Time | How | By Whom |
|---|---|---|---|
| _____ | _____ | _____ | _____ |

Date of Incident: _____ Time of Incident: _____ # of Adults Present _____

Location (circle one): Classroom Gym Hallway Bathroom Playground Sidewalk Bus Other: _____

Was a substitute(s) present: Yes☐ / No☐ If yes, who: _____ # of Students present _____

Description of Incident (circle one) (child/child) (adult/child) (child) (adult) (adult/adult) (child/adult)

**Describe** injury or behavior: _____

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

_____

Choking/Seizure/How long did seizure last: _____

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

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

First Aid Administered (Describe): _____ Action Taken _____

Agencies Notified (Which): _____ Taken to Urgent Care? Yes ☐ No ☐

Is follow up required? If yes explain: (**must notify Health Manager** if medical attention is suggested) _____

_____

Action taken by (Name): _____ Hire date: _____

OFFICE USE ONLY

| Staff involved | Hire Date | Date Last Trained on Active Supervision | Date Background Check Completed |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Does the child have a disability and/or significant behaviors? Y/N (Add supporting information from COR, ChildPlus, etc) If yes, describe: _____

**If an incident involves suspected abuse or neglect, immediately contact Child Services at 1-800-800-5556.**

| | | | |
|---|---|---|---|
| Person Reporting Incident | Date | Quality Assurance Manager | Date |
| Site Supervisor | Date | Executive Director | Date |
| Health Manager/Nurse | Date | Action Taken ☐ | No Action Needed ☐ |
| Human Resource Manager | Date | | |

Revised 11/12/24

Send to Health Cloud, Copy to Parent, original in Child's file.