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)

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):

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

Action Taken _____

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

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

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 ☐

White: Email grantee office, child's file
Revised 11/12/24

Yellow: Appropriate Head Start Manager

Pink: Parent