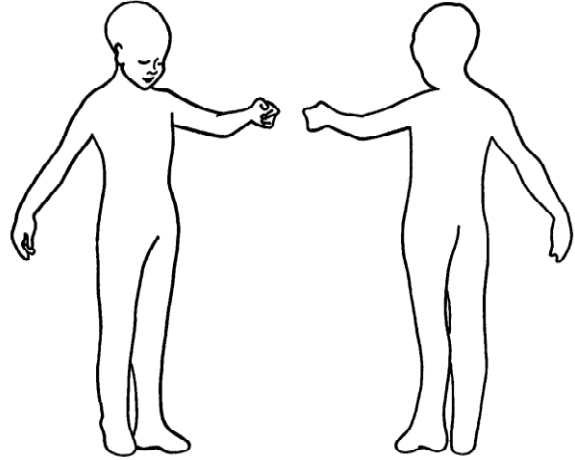


Child Care Injury/Incident Report

Licensee's name and address														
Name of child	Date of incident	Time of incident <input type="checkbox"/> am <input type="checkbox"/> pm												
Describe circumstances of injury/incident														
Where did the injury/incident occur?														
Play equipment, furniture or other items involved?														
Was first aid given? If so, result.	Describe any other treatment given.													
<table style="width: 100%; border: none;"> <tr> <td style="width: 25%;"></td> <td style="text-align: center;">Yes No</td> <td></td> </tr> <tr> <td style="padding-top: 10px;">Were there witness(es)?</td> <td style="text-align: center; padding-top: 10px;"> <input type="checkbox"/> <input type="checkbox"/> </td> <td style="padding-top: 10px;"> If yes, give name(s) _____ _____ _____ </td> </tr> <tr> <td style="padding-top: 10px;">Medical professional contacted?</td> <td style="text-align: center; padding-top: 10px;"> <input type="checkbox"/> <input type="checkbox"/> </td> <td style="padding-top: 10px;"> If yes, give name: _____ Time of contact: _____ </td> </tr> <tr> <td style="padding-top: 10px;">Was parent contacted?</td> <td style="text-align: center; padding-top: 10px;"> <input type="checkbox"/> <input type="checkbox"/> </td> <td style="padding-top: 10px;"> If yes, give name: _____ Time of contact: _____ </td> </tr> </table>				Yes No		Were there witness(es)?	<input type="checkbox"/> <input type="checkbox"/>	If yes, give name(s) _____ _____ _____	Medical professional contacted?	<input type="checkbox"/> <input type="checkbox"/>	If yes, give name: _____ Time of contact: _____	Was parent contacted?	<input type="checkbox"/> <input type="checkbox"/>	If yes, give name: _____ Time of contact: _____
	Yes No													
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Was parent contacted?	<input type="checkbox"/> <input type="checkbox"/>	If yes, give name: _____ Time of contact: _____												

Was licensor contacted?	<input type="checkbox"/>	<input type="checkbox"/> If yes, give name: _____ Time of contact: _____
Was Children's Administration intake contacted?	<input type="checkbox"/>	<input type="checkbox"/> If yes, give name: _____ Time of contact: _____
Any other contacts?	<input type="checkbox"/>	<input type="checkbox"/> If yes, give name: _____ Time of contact: _____

Mark and describe area of injury:



Parent/guardian comments

Parent/guardian signature

Date

Licensee's signature

Date