

INJURY/INCIDENT REPORT FORM

DAYCARE

Provider: _____ Phone: _____

Address: _____

Date **AND** Time of Injury: _____

Injured Child: _____ Date of Birth: _____

Parent Name(s): _____

Address: _____

Home or Cell Phone: _____ Work Phone: _____

Details of Injury: _____

Medical treatment required: YES ☐ NO ☐

If yes, list doctor and clinic/hospital, if known, and what medical treatment was given: _____

When were parents of injured child notified: _____

Signature of Daycare Provider _____ Date _____

Signature of Parent _____ Date _____

PLEASE RETURN THIS FORM TO CHILD CARE LICENSOR WITHIN 24 HOURS OF INJURY