Head Start of Lane County

221 B Street, Springfield OR 97477

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CHILD ACCIDENT REPORT

Child's Name:_____ **ChildPlus ID #:** _____

Staff Completing this form (Printed): _____

Date: _____ **Time:** _____ **Classroom:** _____

Location of Incident: ☐ Classroom ☐ Bathroom ☐ Field Trip ☐ Bus ☐ Playground
☐ Hallway/Stairway ☐ Gym ☐ Other (Please describe): _____

Describe what happened: _____

_____

_____

Staff response: ☐ Gave comfort ☐ Provided Band-Aid ☐ Provided Ice Pack ☐ Contacted EMS

☐ Washed with Soap & Water ☐ Verbal reminder ☐ Removed child/item from area/activity

☐ other: _____

Describe the Injury including body part(s) affected: _____

☐ None visible ☐ Minor ☐ Major ☐ Life Threatening

Exposure to blood borne pathogens and/or bodily fluid(s)? ☐ Yes ☐ No

Was the child seen by a Physician or Emergency Room Personnel?

☐ No ☐ Yes Date: _____ Result: _____

Parent/Guardian Notified: ☐ In-Person ☐ By Phone ☐ By Text/Email ☐Letter Sent Home

Parent/Guardian's Name (Printed): _____ **Signature:** _____

Staff / Interpreter Signature: _____ **Date:** _____

Regional Manager Signature: _____ **Date:** _____

Send to Regional Manager within 24 hours. Confirm it is received if sent electronically.
If Emergency Medical Services were required, contact Management immediately.
If subsequent medical treatment was provided pertinent medical records/documentation need to be provided and uploaded into ChildPlus when received.

WHITE: Parent's Copy
YELLOW: Regional Manager

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