INCIDENT REPORT

DEPARTMENT OF HEALTH AND HUMAN SERVICES
EARLY CHILDHOOD SERVICES
SFN 438 (2-2025)

Clear Fields

Program Name		Telephone Number
Child's Name	Gender ☐ Male ☐ Female	Age
Date of Incident	Time of Incident ☐ AM ☐ PM	Name of Legal Guardian or Parent Notified
Notified By		Time Notified ☐ AM ☐ PM

Location Where Incident Occurred: ☐ **On Site** ☐ **Off Site**

☐ Bathroom	☐ Kitchen	☐ Playground	☐ Classroom	☐ Lunchroom
☐ Doorway	☐ Vehicle	☐ Field Trip	☐ Office	☐ Large Muscle Room/Gym
☐ Hall	☐ Outside	☐ Unknown	☐ Unknown	☐ Other (specify): _____

Describe Equipment Involved (if applicable) (i.e. climber, toy, swing, etc.)

Cause of Injury

☐ Fall to Surface; Estimate Height of Fall _____; Type of Surface _____; Depth of Surface _____

☐ Fall from Running or Tripping	☐ Hit or Pushed	☐ Pinched By:	☐ Bitten By:	☐ Motor Vehicle
☐ Injured by Object	☐ Slipped	☐ Equipment	☐ Human	☐ Cut
☐ Insect Sting/Bite	☐ Eating or Choking	☐ Person	☐ Animal	☐ Unknown/Not Witnessed

☐ Other (specify): _____

Describe Incident

Type of Injury(ies) (check all that apply)

☐ Bite; was skin broken? ☐ Yes ☐ No	☐ Burn	☐ Bump	☐ Scratch	☐ Sting
☐ Crushing Injury	☐ Skinned/Scrape	☐ Nose Bleed	☐ Sprain/Strain	☐ Loss of Consciousness
☐ Sliver	☐ Broken Bone	☐ Puncture	☐ Bruise or Swelling	

☐ Other (specify): _____

Location of Bodily Injury(ies) (check all that apply)

Head	**Trunk**	**Arm:** ☐ R ☐ L	**Leg:** ☐ R ☐ L
☐ Scalp	☐ Neck	☐ Arm	☐ Leg
☐ Face	☐ Collar Bone	☐ Elbow	☐ Ankle
☐ Ear: ☐ R ☐ L	☐ Chest	☐ Wrist	☐ Foot
☐ Eye: ☐ R ☐ L	☐ Stomach	☐ Thumb	☐ Knee
☐ Nose	☐ Buttocks	☐ Finger	☐ Toe
☐ Mouth	☐ Genital Area	☐ Other (specify): _____	☐ Other (specify): _____
☐ Teeth	☐ Shoulder: ☐ R ☐ L		
☐ Tongue	☐ Other (specify): _____		
☐ Lip			
☐ Forehead			

Describe Injury

Describe Action Taken

Was medical attention (at hospital or clinic) required? ☐ Yes* ☐ No

* Reminder - The provider shall report to the department or its authorized agent within twenty-four hours a death or serious accident or illness requiring hospitalization of a child while in the care of the facility or attributable to care received in the facility.

Follow-up Plan (if needed)

Report Prepared By (Staff Signature)	Date
Parent/Legal Guardian (Staff Signature)	Date

Copies to: 1) Parent 2) Provider for Child's File 3) ECS Licensing Specialist