CONFIDENTIAL **4/01**

STUDENT INJURY REPORT
(MEDICAL ATTENTION NEEDED)

NAME OF CENTER_____________________________ DATE OF INJURY________
ADDRESS____________________________________ TIME OF INJURY________

NAME OF CHILD______________________________AGE____ SEX__________

NAME OF PARENT____________________________
ADDRESS____

WAS INJURY CAUSED BY A FALL? YES___ NO___
IF YES, TYPE OF SURFACE____
DID INJURY OCCUR ON PLAYGROUND EQUIPMENT? YES___ NO___
IF YES, TYPE OF EQUIPMENT______________________________________

HOW DID THE INJURY HAPPEN? (DESCRIBE BRIEFLY)_____________________
____
____
____

WHERE DID THE INJURY OCCUR? (INSIDE OR OUTSIDE)___________________

NAME OF STAFF MEMBER IN CHARGE___________________________________
WAS HE OR SHE PRESENT AT SCENE OF INJURY? YES___ NO___

WITNESS TO INJURY (IF ANY)____

WAS CHILD GIVEN FIRST AID? YES___ NO___ __________________________
TYPE OF AID GIVEN?_______________________ (BY WHOM)

WERE PARENTS NOTIFIED? YES___ NO___ __________________________
WHEN?__________________ (BY WHOM)

WAS EMERGENCY TREATMENT PROVIDED AT HOSPITAL/DR. OFFICE/
DENTIST? YES___ NO___ WHERE?____________________________________
RESULT OF INJURY (DIAGNOSIS/TREATMENT)___________________________
____
CORRECTIVE ACTION TAKEN TO PREVENT FURTHER INJURIES____________
____

____
(SIGNATURE OF DIRECTOR)

RETURN TO:

____
(TODAY'S DATE)

BUREAU OF CHILD CARE
CHILD CARE LICENSING
402 WEST WASHINGTON, RM W-386, MS02
INDIANAPOLIS, IN 46204