BRADFORD TIOGA HEAD START, INC.
CHILD OR VOLUNTEER INCIDENT/INJURY FORM

HR 156 5/15

Date of Report: _____ Child/Visitor/Volunteer Name: _____

Individual preparing report _____ Program/Location: _____

Person/s Notified Name: _____; How notified_____; Time Notified_____
Description of Incident _____
_____
_____
_____
_____
Treatment_____
_____
Follow Up_____

Date of Event:	**Sex:** □ M □ F	**Age**:	**Observation Level**: □ 1:1 (has an Aide) □ No Aide	**Status:** □ Enrolled Child □ Visitor □ Volunteer
Time:	**Day of Week**: □Monday □Tuesday □ Wednesday □Thursday □Friday			

INCIDENT/INJURY

- BITE (animal)
- BITE (human)
- BITE (insect)
- BLOOD/BODY FLUID EXPOSURE
- BURN
- CHILD MISSING
- CHOKING
- FALL/SLIP/TRIP
- INGESTION OF FOREIGN OBJECT
- LICE
- INJURY WHILE RESTRAINED
- RESTRAINED
- SEIZURE
- STRUCK BY OBJECT
- STRUCK BY OTHER
- THREAT TO OTHER
- VOMIT
- NOSE BLEED
- OTHER (please explain): _____

INVOLVEMENT

- CHILD ONLY (*i.e. lice, fall, etc.)*
- CHILD TO CHILD
- CHILD TO STAFF
- STAFF TO CHILD
- CHILD TO VISITOR/VOLUNTEER
- SELF-INFLICTED INTENTIONAL
- UNKNOWN
- VISITOR/VOLUNTEER TO CHILD
- OTHER_____

TYPE OF INJURY

- ABRASION/SCRATCH
- BLISTER
- BURN
- CONTUSION/BRUISE
- DAMAGED TEETH
- EDEMA/SWELLING
- FRACTURE
- LACERATION
- PUNCTURE
- RASH/HIVES
- SPRAIN/STRAIN
- STING
- UNKNOWN
- NONE (i.e. lice)
- OTHER: _____

SEVERITY OF INJURY TO CHILD

- MINOR
- MODERATE
- NONE
- SERIOUS
- UNKNOWN
- OTHER:_____

LOCATION

- BATHROOM
- CLASSROOM
- CAFETERIA
- PLAYGROUND
- HALLWAY/CORRIDOR
- KITCHEN
- PARKING LOT
- STAIRS
- VEHICLE – FACILITY
- VEHICLE – PUBLIC/PRIVATE
- WALKWAY/SIDEWALK
- OTHER: _____

CENTRAL OFFICE USE ONLY:

CORRECTIVE ACTION PLAN
Does event need to be documented on a Serious Event Checklist? ____yes ____no
IF YES. CENTRAL OFFICE SUPERIVSOR WILL DOCUMENT THE CORRECTIVE ACTION PLAN TO PREVENT SITUATION FROM HAPPENING AGAIN (*i.e. modify environment, situation, groups, etc.).*

BE DESCRIPTIVE *(for example: if it is a fall or a slip, what caused it? Get details carpet damaged/sticking up and needs to be replaced, surface was wet, poor lighting, and the follow up plan that was completed so it doesn't happen again i.e. carpet taped, replaced, etc.).* Include the information and follow-up conversation that was held with employee and/or direct supervisor.

DATE COMPLETED: _____

CORRECTIVE ACTION PLAN DETAILS:

_____
_____
_____
_____
_____
_____

PERSONS REVIEWED ACTION PLAN FOLLOW-UP WITH (i.e. employee and/or supervisor name): _____
_____

CENTRAL OFFICE SUPERIVSOR WILL COMPLETE CORRECTIVE ACTION PLAN AND FOLLOW-UP; WILL REVIEW WITH EMPLOYEE AND DIRECT SUPERVISOR. ALL INFORMATION WILL BE ENTERED INTO THE GOOGLEDOCS SPREADSHEET AND TRACKED.

CENTRAL OFFICE SUPERVISOR WILL CONTACT THE DIRECTOR IMMEDIATELY WHEN/IF A SERIOUS EVENT CHECKLIST WAS INITIATED DUE TO CHILD SEEKING MEDICAL TREATMENT DUE TO INJURY.

_____ _____
Central Office Supervisor Signature Date

_____ _____
Program Director Signature (if applicable) Date