

Child Care Injury/Incident Report

Child's Name:			
In addition to reporting to the department by phone or email about the following incidents and injuries, a provider must also complete this incident report and submit it to DCYF within 24-hours.			
Provider Name			Provider ID
Child's Age	Date of Incident	Time of Incident <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Incident Occurred <input type="checkbox"/> Indoors <input type="checkbox"/> Outdoors
List names of staff present and/or witnesses:		Treatment provided to child while in care & by who:	
Check All That Apply			
Situation that required an emergency response from:			
<input type="checkbox"/> Emergency services (911) 110-300-0475(2)(b)/110-301-0475(2)(b)	<input type="checkbox"/> Washington poison center 110-300-0475(2)(c)/110-301-0475(2)(c)	<input type="checkbox"/> Department of Health 110-300-0475(2)(d)/110-301-0475(2)(d)	
Situations that occur while children are in care that may put children at risk including, but not limited to:			
<input type="checkbox"/> Inappropriate sexual touching	<input type="checkbox"/> Physical abuse	<input type="checkbox"/> Neglect	<input type="checkbox"/> Maltreatment
<input type="checkbox"/> Other	<input type="checkbox"/> Exploitation		
Serious injury to a child in care:			
<input type="checkbox"/> Severe bleeding	<input type="checkbox"/> One or more broken bones	<input type="checkbox"/> Choking or serious unexpected breathing problems	
<input type="checkbox"/> Severe neck/head injury	<input type="checkbox"/> Sudden unconsciousness	<input type="checkbox"/> Dangerous chemicals in eyes, on skin, or ingested	
<input type="checkbox"/> Near drowning	<input type="checkbox"/> Shock or acute confused state	<input type="checkbox"/> Severe burn requiring professional medical care	
<input type="checkbox"/> Poisoning	<input type="checkbox"/> Overdose of chemical substance	<input type="checkbox"/> Injury resulting in overnight hospital stay	
Please give a brief description of the injury/incident, including where it occurred.			
Parent/Guardian Contacted		Licensor Contacted	
Date:	Time:	<input type="checkbox"/> In Person <input type="checkbox"/> Phone <input type="checkbox"/> E-mail	Date:
		<input type="checkbox"/> In Person <input type="checkbox"/> Phone <input type="checkbox"/> E-mail	Time:
Parent/Guardian Comments:			
Parent/Guardian Signature		Licensee/Staff Signature	
Date		Date	
<i>By signing this form, I acknowledge that I received a copy of this report.</i>			