DEPARTMENT OF CHILDREN AND FAMILIES
Division of Early Care and Education

dcf.wisconsin.gov

Incident Report – Regulated Child Care Centers

Use of form: This form is voluntary; however, completion of this form meets the requirements of DCF 202.08(1)(c)1., 250.04(3)(a), 251.04(3)(a) and 252.41(2)(a) of the Wisconsin Administrative Codes. Failure to comply may result in an enforcement action or issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wis. Stats.].

Instructions: The licensee / certified provider shall report any death of a child in care, or any incident or accident that occurs while the child is in care that results in an injury that requires professional medical treatment. Licensee shall notify the department within 48 hours of becoming aware of the medical treatment. Certified provider shall notify the certifying agency as soon as possible but no later than the agency's next working day. Submit a completed form to the regional licensing / certification office. Retain a copy in the child's record.

CHILD CARE CENTER INFORMATION

Name – Child Care Center / Certified Provider	Facility / Provider Number	Telephone Number

Address – Child Care Center / Certified Provider (Street, City, State, Zip Code)

CHILD AND PARENT INFORMATION

Name – Child	Birthdate (mm/dd/yyyy)

Name – Parent(s) / Guardian(s)

Telephone Number – Child's Home	Telephone Number – Parent / Guardian – Home	Telephone Number – Parent / Guardian – Work

INCIDENT INFORMATION

Incident Location	Incident Date	Incident Time ☐ A.M. ☐ P.M.

Names – Adult Witnesses

Incident Description

Nature and Extent of Injury

If a Toy was Involved in the Incident – Name and Type

Activity in Which Child was Engaged When Incident Occurred – Describe

How Parent was Notified of Incident – Describe (Include date and time)

Action Taken (e.g., first aid, clean up, decontamination, etc.)

MEDICAL INFORMATION

Name – Hospital or Clinic	Name – Physician

Address – Hospital or Clinic (Street, City, State, Zip Code)

Medical Treatment Provided by Medical Professional – Describe

SIGNATURE – Child Care Center Representative / Certified Child Care Provider	Date Signed

FOR DEPARTMENT USE ONLY

☐ Yes ☐ No Is additional investigation required? If "Yes" attach written report.

Date Reviewed	**SIGNATURE** – Licensing Specialist / Certification Worker