

Ohio Department of Job and Family Services  
INCIDENT/INJURY REPORT FOR CHILD CARE

Child Care Center  Family Child Care  In-Home Aide

<b>SECTION I</b>			
Name of program		Program Number	
Street Address	City	Zip	County
Is this a child who has a written medical/physical care plan on file as defined in the Ohio Administrative Code? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, explain in summary section)</i>			
Full name of Child <i>(first name, last name)</i>		Child's date of birth (MM/DD/YY)	<input type="checkbox"/> Female <input type="checkbox"/> Male
Date of incident/injury/illness		Time of incident/injury/illness	
Name of person responsible for child at time of incident			Witness(es)
At the time of the incident/injury/illness: How many children were there in this child's group? _____ How many child care staff members were supervising the group? _____			
Were parents contacted? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, when? _____		Who provided first aid? _____ Date _____	
How many hours is this child in your care per day? <i>(check one)</i> <input type="checkbox"/> Part-time (<four hours per day) <input type="checkbox"/> Full-time (>four hours per day)			
Age of child-group that child was assigned to at the time of the incident/injury/illness <input type="checkbox"/> Young Infant (Less than 12 months) <input type="checkbox"/> Infant (12-18 months) <input type="checkbox"/> Toddler (18 months – 3 years) <input type="checkbox"/> Preschooler (3-5 years & not in school) <input type="checkbox"/> School Age Child (eligible for kindergarten and older)			
<b>SECTION II</b>			
<b>TYPE OF INJURY</b> <i>(check all that apply)</i>		<b>BODY PART AFFECTED</b> <i>(check apply that apply)</i>	
<input type="checkbox"/> Bit Tongue/Cheek/Lip	<input type="checkbox"/> Object Inserted into body Part	<input type="checkbox"/> Arm	<input type="checkbox"/> Head
<input type="checkbox"/> Bite-human	<input type="checkbox"/> Puncture Wound	<input type="checkbox"/> Back	<input type="checkbox"/> Knee
<input type="checkbox"/> Bite/Sting-Animal or Insect	<input type="checkbox"/> Scrape/Scratch	<input type="checkbox"/> Chin	<input type="checkbox"/> Leg
<input type="checkbox"/> Bump/ Bruise	<input type="checkbox"/> Something in Eye	<input type="checkbox"/> Ear	<input type="checkbox"/> Lungs/Difficulty Breathing
<input type="checkbox"/> Burn	<input type="checkbox"/> Stubbed finger/Toe	<input type="checkbox"/> Eye	<input type="checkbox"/> Mouth/Teeth
<input type="checkbox"/> Choking	<input type="checkbox"/> Sunburn	<input type="checkbox"/> Face	<input type="checkbox"/> Neck
<input type="checkbox"/> Cut	<input type="checkbox"/> Swelling/Redness	<input type="checkbox"/> Fingers	<input type="checkbox"/> Nose
<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> NA – Incident/Illness	<input type="checkbox"/> Foot	<input type="checkbox"/> Shoulder/Collarbone
<input type="checkbox"/> Nosebleed		<input type="checkbox"/> Front of Trunk/Stomach	<input type="checkbox"/> Throat
		<input type="checkbox"/> Genitals/Buttocks	<input type="checkbox"/> Toe
		<input type="checkbox"/> Hand	<input type="checkbox"/> Whole body
<b>TYPE OF ILLNESS</b> <i>(check all that apply)</i>			
<input type="checkbox"/> Diaper Rash <input type="checkbox"/> Fever <input type="checkbox"/> Stomach ache/vomiting/Diarrhea <input type="checkbox"/> Other illness (specify in summary section) <input type="checkbox"/> N/A – Injury/Incident			
<b>TYPE OF INCIDENT</b> <i>(check all that apply)</i>			
<input type="checkbox"/> Baby Fed Wrong Bottle <input type="checkbox"/> Collision w/Object <input type="checkbox"/> Fall – Walk/Run/Trip <input type="checkbox"/> Fighting <input type="checkbox"/> Blood or Bruise Found on Child <input type="checkbox"/> Collison w/Person <input type="checkbox"/> Fall to Surface <input type="checkbox"/> N/A Injury/Illness			
<b>WHERE DID INCIDENT/INJURY HAPPEN?</b> <i>(check all that apply)</i>			
<input type="checkbox"/> Bathroom <input type="checkbox"/> Classroom <input type="checkbox"/> In Vehicle <input type="checkbox"/> On Fieldtrip/Routine Trip <input type="checkbox"/> Pool <input type="checkbox"/> Changing Table <input type="checkbox"/> Hall/Doorway <input type="checkbox"/> Inside Play area/Large Muscle Area <input type="checkbox"/> Outdoor Play Area <input type="checkbox"/> Stairway <input type="checkbox"/> Crib <input type="checkbox"/> High Chair <input type="checkbox"/> Kitchen/Eating Area <input type="checkbox"/> Parking Area/Driveway <input type="checkbox"/>			
<b>INCIDENT HAPPENED DURING?</b>			
<input type="checkbox"/> Arrival/Departure <input type="checkbox"/> Diaper Change <input type="checkbox"/> Naptime/Rest Period <input type="checkbox"/> Bus/Vehicle/During Transportation <input type="checkbox"/> Indoor Play/Group Activities/Free Play <input type="checkbox"/> Outdoor Play <input type="checkbox"/> Classroom Activity <input type="checkbox"/> Meals/Snacks <input type="checkbox"/> Transition Between Activities			
<b>ACTION TAKEN</b> <i>(check all that apply)</i>			
<input type="checkbox"/> Bandage <input type="checkbox"/> Ice <input type="checkbox"/> Returned to Normal Activity <input type="checkbox"/> Body Part Elevated <input type="checkbox"/> Pressure Applied <input type="checkbox"/> Sent Home Early/Picked Up Early <input type="checkbox"/> Contacted Children's Protective Services <input type="checkbox"/> Referred for Further Medical Care <input type="checkbox"/> Washed/Soaped <input type="checkbox"/> Hug/Pat <input type="checkbox"/> Rested on Cot <input type="checkbox"/>			
Summary of incident/injury/illness <i>(Explain, attach additional paper if needed)</i>			
<b>Print</b> First and Last Name of Person Completing Form		Signature of Person Completing Form	
		Telephone Number	
Person Receiving Form – Parent/Family Member <i>(Optional – for record keeping purposes only)</i>			Date

### **Incident/Injury Report Instructions**

**A JFS 01299 “Incident/Injury Report” must be completed when:**

- A child becomes ill or receives an injury which requires any first aid treatment.

**FILL IN REQUIRED SECTIONS I ON THE FRONT SIDE OF THIS FORM.** Provide a complete description of the incident/injury/illness in the summary section (if additional space is needed, attach paper to the incident report). The person completing the form signs the report and it is provided on the same day of the incident to the parent/guardian or person picking up the child from the center/home. Request parent/guardian/caregiver to sign report; however, do not delay giving report to parent if parent refuses to sign. The parent’s signature is *not* required. **PLEASE BE SURE ALL SECTIONS HAVE BEEN COMPLETED.**

### **DEFINITIONS**

**Incident:** An unusual event that happens that does not necessarily result in an injury to the child. A copy of the report for an incident shall be retained on file at the center or home for at least one year and shall be available for review by the Ohio Department of Job and Family Services/county agency.

**Minor Injury:** An injury resulting in a child being able to return to normal activity; basic first aid may be given by staff. A copy of the report for a minor injury shall be retained on file at the center or home for at least one year and shall be available for review by Ohio Department of Job and Family Services/county agency.

**Child care providers may contact the Child Care Policy Help Desk toll-free  
At (877) 302 2347 Option 4, for technical assistance.**