

# INCIDENT REPORT FORM

55 PA CODE CHAPTERS 3270.20 & .182(7); 3280.19 & .182(7); 3290.17 & .182(7)

THIS FORM CAN BE USED TO MEET THE REPORTING REQUIREMENTS FOR ACCIDENT, INJURY, ILLNESS, HOSPITALIZATION, EMERGENCY ROOM TREATMENT, DEATH OR FIRE

NAME OF FACILITY		TELEPHONE NUMBER
FACILITY ADDRESS		
NAME OF CHILD	SEX <input type="checkbox"/> M <input type="checkbox"/> F	BIRTHDATE
CHILD ADDRESS		
NAME OF PARENT		TELEPHONE NUMBER
PARENT ADDRESS		
PARENT NOTIFIED BY		TIME NOTIFIED <input type="checkbox"/> A M <input type="checkbox"/> P M

DESCRIPTION OF INCIDENT			
DATE	TIME <input type="checkbox"/> A M <input type="checkbox"/> P M	LOCATION	
EQUIPMENT/PRODUCT INVOLVED	TYPE OF INJURY	PART OF BODY INJURED	
CAUSE OF INJURY			

ACTION TAKEN			
FIRST-AID GIVEN BY FACILITY			
NAME OF LOCAL AUTHORITY NOTIFIED OF INCIDENT			TELEPHONE NUMBER
ADDRESS			
TREATMENT PROVIDED BY	TELEPHONE NUMBER	ADDRESS	
NATURE OF TREATMENT			
REQUIRED FOLLOW-UP			

_____	_____	_____
SIGNATURE OF FACILITY PERSON COMPLETING FORM	TITLE	DATE
_____	_____	_____
SIGNATURE OF PARENT		DATE

COMPLETE THE FOLLOWING SECTION ONLY IF THE INCIDENT RESULTED IN INPATIENT HOSPITALIZATION, EMERGENCY ROOM TREATMENT, SERVICES OF A FIRE COMPANY, OR THE DEATH OF A CHILD RECEIVING CARE AT THE FACILITY.		
NOTIFY REGIONAL DAY CARE OFFICE WITHIN 24 HOURS	DATE OF NOTIFICATION	TIME OF NOTIFICATION
NAME OF THE REGIONAL DAY CARE STAFF PERSON NOTIFIED		
MAIL OR DELIVER WRITTEN REPORT TO REGIONAL OFFICE WITHIN 72 HOURS		
_____	_____	_____
SIGNATURE OF FACILITY PERSON WHO MADE THE NOTIFICATION	TITLE	