Policy: Complete the Illness/Incident Report when a child experience any of the following: accidents, injuries, incidents, or changes in health. If necessary, notify the parent/guardian as soon as possible. When a child is too ill to remain in the group, notify a parent/guardian and document the illness on this form. If a child receives medical treatment or is hospitalized, make a verbal report to LARA within 24 hours of the occurrence. Submit a written BCAL-4605 Incident Report within 72 hours of the verbal report. Any significant incidents affecting the health and safety of program participants will be reported to OHS/ISD immediately by CFD management. Contact the Supervisor if a staff member learns that a child has received medical treatment after an accident or incident that occurred while in our care.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Child’s Full Name | Date of Birth | Date of Incident | Time of Incident | Full Name of Supervisor or Director Notified | | |
| Site Name | Classroom (circle)  1 2 3 | Full Name of Staff Person Reporting the Incident | | | Number of Staff Counted in the  Ratio at Time of Incident | |
| Full Name(s) of Staff Member(s) Located in the Active Supervision Zone | | | | Emergency Care Plan (ECP)?   * Yes * No | | * Attach ECP if Relevant |
| Full Name of Parent/Guardian Notified | | | Time Notified   * AM * PM | | Notified   * In Person * By Report | * Phone * Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

CHECK ALL THAT APPLY

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Type of Illness Observed   * Allergic Reaction/Asthma * Breathing/No Pulse * Diaper Rash * Diarrhea/Stomachache/Vomiting * Faint/Collapse * Fever: Time Temp was Taken  |  |  | | --- | --- | | AM |  | | PM |  |  * Seizure * Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Body Part(s) Injured   * Ankle/Foot/Knee/Leg/Toe * Arm/Finger/Hand/Wrist * Back * Buttocks/Genitals * Chin/Ears/Eyes/Face/Mouth/Tooth * Collar Bone/Shoulder * Difficulty Breathing/Lungs * Front of Trunk/Stomach * Head * Neck/Throat * Whole Body * Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Type of Injury   * Bit Cheek/Lip/Tongue * Bite-Animal/Human/Insect * Blow to Head * Broken Bone * Bruise/Bump * Burn * Choking * Cut * Difficulty Breathing * Tooth-chipped/knocked out/loosened | | * Injured by Object * Nosebleed * Object in Eye * Poisoning * Puncture Wound * Scrape/Scratch * Stubbed Finger/Toe * Sunburn * Swelling/Redness * Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Location of Incident   * Bathroom * Classroom * Doorway * Field Trip * Gym * Hall * Playground * Stairs * Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Equipment Involved   * Carpet/Floor * Climber * Playground Surface * Slide * Swing * Toy (specify \_\_\_\_\_\_\_\_\_\_\_\_\_) * Trike/Bike * Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Action Taken   * Bandage * Body Part Elevated * Contacted Poison Control * Emergency Services Notified * Emergency Services   Transported Child   * Ice * Picked Up Early or   Sent Home Early | | * Comfort/Hug * Health Department * Pressure Applied * Referred for further Medical Care * Rested * Returned to Normal Activity * Washed/Soap * Changed to Dry Clothes in Bathroom * Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Did the incident involve exposure to blood borne pathogens or bodily fluids?   * Yes * No | | | Type of Incident   * Prohibited Items Brought from Home * Wet or Soiled Clothes * Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Description of Accident, Injury, Incident, or Illness: | | | | | | |

**If Emergency Action Needed: The center staff must make a verbal report to LARA within 24 hours of occurrence Submit BCAL-4605 to LARA within 72 hours.**

|  |  |  |
| --- | --- | --- |
| Was the child seen by a doctor or will the child seek emergency room medical treatment?   * Yes * No | Taken for Medical Treatment by   * Ambulance * Parent/Guardian * Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | If applicable, Time 911 Notified |
| Corrective Action to Prevent Recurrence | | |

Signature of Person Completing Report: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reference: HSPPS 1302.41(a)(b), R400.8155(1), Special Investigation and OHS Reporting Guidance. Original: Child’s File (L#16)

7/8/23 Copy: Program Support, Parent/Guardian, Supervisor, Coach EHS-HS Team\\Procedure Manual\Health\Illness Incident Report