



Illness/Incident Report

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)?	<input type="checkbox"/> Attach ECP if Relevant
				<input type="checkbox"/> Yes	
				<input type="checkbox"/> No	
Full Name of Parent/Guardian Notified			Time Notified	Notified	
				<input type="checkbox"/> In Person	<input type="checkbox"/> Phone
				<input type="checkbox"/> By Report	<input type="checkbox"/> Other _____

CHECK ALL THAT APPLY

Type of Illness Observed <input type="checkbox"/> Allergic Reaction/Asthma <input type="checkbox"/> Breathing/No Pulse <input type="checkbox"/> Diaper Rash <input type="checkbox"/> Diarrhea/Stomachache/Vomiting <input type="checkbox"/> Faint/Collapse <input type="checkbox"/> Fever: Time Temp was Taken <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50px;">AM</td> <td></td> </tr> <tr> <td>PM</td> <td></td> </tr> </table> <input type="checkbox"/> Seizure <input type="checkbox"/> Other _____	AM		PM		Body Part(s) Injured <input type="checkbox"/> Ankle/Foot/Knee/Leg/Toe <input type="checkbox"/> Arm/Finger/Hand/Wrist <input type="checkbox"/> Back <input type="checkbox"/> Buttocks/Genitals <input type="checkbox"/> Chin/Ears/Eyes/Face/Mouth/Tooth <input type="checkbox"/> Collar Bone/Shoulder <input type="checkbox"/> Difficulty Breathing/Lungs <input type="checkbox"/> Front of Trunk/Stomach <input type="checkbox"/> Head <input type="checkbox"/> Neck/Throat <input type="checkbox"/> Whole Body <input type="checkbox"/> Other _____	Type of Injury <input type="checkbox"/> Bit Cheek/Lip/Tongue <input type="checkbox"/> Bite-Animal/Human/Insect <input type="checkbox"/> Blow to Head <input type="checkbox"/> Broken Bone <input type="checkbox"/> Bruise/Bump <input type="checkbox"/> Burn <input type="checkbox"/> Choking <input type="checkbox"/> Cut <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Tooth-chipped/knocked out/loosened <input type="checkbox"/> Injured by Object <input type="checkbox"/> Nosebleed <input type="checkbox"/> Object in Eye <input type="checkbox"/> Poisoning <input type="checkbox"/> Puncture Wound <input type="checkbox"/> Scrape/Scratch <input type="checkbox"/> Stubbed Finger/Toe <input type="checkbox"/> Sunburn <input type="checkbox"/> Swelling/Redness <input type="checkbox"/> Other _____
AM						
PM						

Location of Incident <input type="checkbox"/> Bathroom <input type="checkbox"/> Classroom <input type="checkbox"/> Doorway <input type="checkbox"/> Field Trip <input type="checkbox"/> Gym <input type="checkbox"/> Hall <input type="checkbox"/> Playground <input type="checkbox"/> Stairs <input type="checkbox"/> Other _____	Equipment Involved <input type="checkbox"/> Carpet/Floor <input type="checkbox"/> Climber <input type="checkbox"/> Playground Surface <input type="checkbox"/> Slide <input type="checkbox"/> Swing <input type="checkbox"/> Toy (specify _____) <input type="checkbox"/> Trike/Bike <input type="checkbox"/> Other _____	Action Taken <input type="checkbox"/> Bandage <input type="checkbox"/> Body Part Elevated <input type="checkbox"/> Contacted Poison Control <input type="checkbox"/> Emergency Services Notified <input type="checkbox"/> Emergency Services Transported Child <input type="checkbox"/> Ice <input type="checkbox"/> Picked Up Early or Sent Home Early <input type="checkbox"/> Comfort/Hug <input type="checkbox"/> Health Department <input type="checkbox"/> Pressure Applied <input type="checkbox"/> Referred for further Medical Care <input type="checkbox"/> Rested <input type="checkbox"/> Returned to Normal Activity <input type="checkbox"/> Washed/Soap <input type="checkbox"/> Changed to Dry Clothes in Bathroom <input type="checkbox"/> Other _____
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Did the incident involve exposure to blood borne pathogens or bodily fluids? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of Incident <input type="checkbox"/> Prohibited Items Brought from Home <input type="checkbox"/> Wet or Soiled Clothes <input type="checkbox"/> Other _____
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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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Taken for Medical Treatment by <input type="checkbox"/> Ambulance <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Other _____	If applicable, Time 911 Notified
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Corrective Action to Prevent Recurrence

Signature of Person Completing Report: _____ Date: _____