



PROGRAM INFORMATION

Program Name: _____ License #: _____ Phone #: _____
Director/Provider: _____ Reported to CCLU by: _____
if required

CHILD INFORMATION

Child's Name: _____ Gender: Male Female Date of Birth: _____ Age: _____

INJURY / INCIDENT INFORMATION

Date of Incident: _____ Time of Incident: _____ am pm Called 911 Called Poison Control
Description of Incident: _____

Cause of Injury/Incident: _____

Location Incident Occurred: Bathroom Common Areas In a vehicle Kitchen Off the premises
 Classroom/Child Care Room Outside Other: _____

Witness(s): _____

Side of Body Affected: _____ Body Part Affected: _____

Type of Injury/Incident - all injuries marked with an *asterisk *must* be reported to CCLU per He-C 4002.19(ah)

- Broken Bone/Fracture*** **Burn*** **Concussion*** **Death*** **Dislocation*** **Loss of Consciousness***
- Stitches/Glue*** Allergy/Sensitivity Reaction Open wound/cut Pain/Inflammation/Bump Poisoning
- Respiratory Condition Seizure Sprain/Twist/Strain Other: _____

TREATMENT INFORMATION

Onsite Treatment Given (by staff): _____
_____ by whom: _____

***Outside Professional Medical Treatment Given: (if applicable)** _____

Taken to Clinic/Hospital/Doctor: _____ by whom: _____

NOTIFICATION INFORMATION

Parent/Guardian Contacted: _____ by whom: _____

Contact date: _____ Time: _____ am pm Method: In Person Phone E-mail

Print Parent/Guardian Name: _____ Signature: _____

Date: _____ Time: _____ am pm Director/Provider Signature: _____

Witness(s) Signature(s): _____

Contact to CCLU: Call (name of CCLU staff: _____ date: _____ time: _____ am pm)

Fax (date: _____ time: _____ am pm)

mail (date: _____) -only as follow up to phone call notification

Contact CCLU via phone (271-9025) or Fax (271-4782) within 48 hours of knowledge for all items indicated with a *. All notifications made by phone must be followed up with this report within 1 week. All reports must be maintained for 3 years, on site, in a separate file. Signed copy to parent.