

# ACCIDENT REPORT FORM

DATE: \_\_\_\_\_

CHILD CARE PROVIDER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

TELEPHONE NUMBER: (\_\_\_\_)\_\_\_\_\_

CHILD(REN) INJURED: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

DATE AND TIME OF INJURY: \_\_\_\_\_

NATURE OF INJURY: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

MEDICAL TREATMENT REQUIRED: YES  NO

IF YES, LIST DOCTOR AND CLINIC/HOSPITAL, IF KNOWN, AND WHAT MEDICAL TREATMENT WAS GIVEN: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

WHEN WERE PARENTS OF CHILD NOTIFIED: \_\_\_\_\_

PARENTS NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

TELEPHONE NUMBER: (\_\_\_\_)\_\_\_\_\_

WORK TELEPHONE NUMBER: (\_\_\_\_)\_\_\_\_\_

\_\_\_\_\_  
Signature of Child Care Provider

\_\_\_\_\_  
Signature of Parent

\*Please return this form to Child Care Licensor within 24 hours of injury.