

## Incident/Illness Report

Use this form to collect all required information when a child sustains an injury, at the onset of an illness, or reportable incident.

**Directions:** The employee who observes the incident completes and signs the form. Parents are provided the form within 48 hours of the incident/injury. The day care provider keeps the form on file at the child care facility.

### General Information

Caregiver in Charge:		Director's Name:		Child's Full Name:		Child's Date of Birth:	
Time Parent Notified: <input type="checkbox"/> AM <input type="checkbox"/> PM		Date of Incident/Illness:		Location of Incident/Illness:		Time of Incident/Illness: <input type="checkbox"/> AM <input type="checkbox"/> PM	
Licensing Notified, if Required <input type="checkbox"/> Yes <input type="checkbox"/> No		Date:		Time:		By:	
Parent or Guardian Name:				Parent Area Code and Telephone No.:			
Was Medical Attention Required? <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____ Time: _____		Was EMS called? <input type="checkbox"/> Yes <input type="checkbox"/> No Time called: _____ Was Child Transported? <input type="checkbox"/> Yes <input type="checkbox"/> No		Doctor Called by Operation? <input type="checkbox"/> Yes <input type="checkbox"/> No Time: _____ Doctor Recommendation:			
Was First Aid Provided? <input type="checkbox"/> Yes <input type="checkbox"/> No What was done?							
Child's Doctor:		Doctor's Area Code and Telephone No.:		Did child see his/her doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No		Diagnosis:	

### Details of Incident/Illness

Describe the injury or risk to child:
How did the incident/injury occur?
Additional staff present and/or witness to the incident/injury:

**Details of Onset of Illness While in Care**

Type of illness:			
If communicable, all parents notified? <input type="checkbox"/> Yes <input type="checkbox"/> No  Notified by: _____	Does the illness require exclusion from care? <input type="checkbox"/> Yes <input type="checkbox"/> No	Health Department notified? <input type="checkbox"/> Yes <input type="checkbox"/> No  Date: _____	
Allergy plan enacted? <input type="checkbox"/> Yes <input type="checkbox"/> No	Medication given:	Temperature of child:	
Signature of Staff completing report:	Date:	Signature of Director:	Date:

**Parent or Guardian Acknowledgment**

I verify that the director/person in charge appropriately relayed the information concerning the incident/injury concerning my child. I have received a copy of this report.	
Signature of Parent or Legal Guardian:	Date Signed:

**Privacy Statement**

HHSC values your privacy. For more information, read the privacy policy online at: <https://hhs.texas.gov/policies-practices-privacy#security>