CAPNEMO Head Start Incident/Accident/Illness Report

Center: ______________________________________ Supervisor: __________________________________

An Incident/Accident/Illness is any occurrence or situation which is not consistent with the routine operation of the center or the routine care of a particular child. It may be an accident or a situation which may present a hazard to children and/or the operation of the center.

Person Involved: _______________________________ (Circle) Adult / Child Male / Female Age ________

If a visitor to the center, state reason for presence: ____

Date of Incident/Accident/Illness ___________________ Time ______ AM/PM Location _______________________

"Illness" Staying constant (√) ___ Getting Better (√) ___ Getting Worse (√) ___ how long it lasted _____

Circle Symptons:

Breathing: *Coughing* *Wheezing* *Breathing fast* *Difficulty breathing* *Other:* __________________

Skin: *Pale* *Flushed* *Rash* *Sores* *Swelling* *Bruise* *Itching* *Other:* ___________________

Vomiting: *# of times* ____ **Diarrhea:** *# of times* ____ **Urine:** ______________________________________

Eyes: *Pink/red* *Watery* *Discharge* *Crusty* *Swollen* *Other:* ______________________________

Ears: *Pulling at ears* *Discharge* *Other:* ___________ **Nose:** *Congested* *Runny* *Other:* ______________

Mouth: *Sores* *Drooling* *Difficulty Swallowing* *Other:* _______________________________________

Odor(s): *(e.g., breath, stool)* ____

Temperature: _________________ *Axillary / Oral / Rectal (circle)*

What Has Been Done: *Comfort* ____________________________ *Rest* ____________________________________

Liquids: *Name* ________________________ *Amount* _________________________ *Time(s)* __________________

Medications: *Name* ____________________ *Amount* _________________________ *Time(s)*___________________

Emergency Measures: ____

"Incident/Accident"

Describe what happened and why. *If injury occurred, describe the part of the body injured and the nature of the injury.*

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Was person seen by a physician? *Yes / No* *Physician's Name* _______________________ *Date:* ______*Time* ________

Physician's Diagnosis: ____

Does person need further treatment or follow up? *Yes / No* **Was there property damage?** *Yes / No* If yes, please describe: ____

Who was notified? ____________________________ *(e.g., parent/guardian, emergency contact, EMS, health provider)*

When were they notified? *Date* _________________ *Time:* _____________ *AM / PM*

Parent Signature____ **Date** _____________________

Attending Staff Signature ____ **Date** _____________________