



### 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 Doe Valley Day Camp provider keeps the form on file at the Day Camp 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	
Parent of Guardian Name:				Parent Phone Number:			
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 Day Camp: <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 Phone Number		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 Day Camp? <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: _____