State of Montana
Department of Public Health and Human Services
Quality Assurance Division – Licensure Bureau
Child Care Licensing

ACCIDENT / INJURY REPORT

*Accidents causing injury to a child which result in the child being hospitalized, requiring ambulance transport or intervention, or physician treatment must be reported to the appropriate local office of the department within 24 hours. ARM 37.95.183(5)
*A notation of all injuries must be made in the child’s medical record. ARM 37.95.183(6)

Facility Name: ___________________________ PV#: ___________________________

Name of Injured Child: ___________________________ Birth Date: _______________

Date of Accident / Injury: ___________________________ Time of Injury: _______________

Location of Accident / Injury: ___________________________

Describe incident: (what was the child doing at the time he/she was injured, condition of premises, what happened)

________________________________________

________________________________________

________________________________________

________________________________________

Type of injury and body part injured: ___________________________

________________________________________

Staff person(s) responsible for supervision of injured child at time of injury: ___________________________

________________________________________

– SEE REVERSE SIDE –
Witnesses to the accident / injury:

Name: ______________________________________ Name: ______________________________________
Name: ______________________________________ Name: ______________________________________

What first aid action was taken? ________________________________________________________________

__________________________________________________________
Date first aid provided: __________________________ Time first aid provided: __________________
Name of staff person who administered first aid: __________________________________________________

Where was the child taken after the accident? ______________________________________________________

How was the child transported? __________________________ Who transported the child? __________________
What, if any, medical treatment was administered? _________________________________________________

__________________________________________________________
Method of parent notification: _________________________________________________________________
Date of parent notification: __________________________ Time of parent notification: _________________

PARENT SIGNATURE __________________________ DATE ____________

STAFF / WITNESS SIGNATURE __________________________ DATE ____________

STAFF / WITNESS SIGNATURE __________________________ DATE ____________

STAFF / WITNESS SIGNATURE __________________________ DATE ____________

STAFF / WITNESS SIGNATURE __________________________ DATE ____________

DIRECTOR / STAFF SIGNATURE __________________________ DATE ____________