

TOWN OF SECAUCUS
GENERAL INCIDENT REPORT



DATE OF REPORT: _____ DATE OF INCIDENT: _____ TIME OF INCIDENT: _____ A.M./P.M.

FACILITY/PROGRAM: _____

PERSONAL DATA – INVOLVED AND/OR INJURED PARTY

Name: _____	DOB: _____	[] Male	[] Female
Address: _____	City: _____	State: _____	Zip: _____
Home Phone: _____	Cell: _____	Work: _____	
Family Contact (if minor or has a legal guardian):			
Name: _____	Phone #: _____		

INCIDENT DATA **Please attach additional sheets if needed for the full description of the incident.

Location of the incident [Facility name, location within the facility, etc.]:

Description of the incident:

Staff present at time of the incident:

Is there a video of the location or of the incident available? [] Yes [] No

Did an injury occur? [] Yes [] No

If yes, describe the type of injury:

MEDICAL/FIRST AID CARE

Did the individual require medical/first aid care? Yes No
Did the individual refuse medical/first aid care or offer to call for help by staff? Yes No

If possible, please have the individual initial here if they are refusing medical attention. _____

Did facility staff provide medical/first aid to the individual? Yes No

Name of staff member that provided medical/first aid: _____

Describe in detail medical/first aid care given: _____

Was EMS called? Yes No

If yes, by whom: _____ Time: _____ A.M./P.M.

Was the individual transported to an emergency facility? Yes No

If yes, to which facility and where? _____
If no, did person return to activity? Yes No or if no, explain: _____

FOR MINORS

If the individual is a minor, was parent/guardian called? Yes. If yes, when: _____ No

Name of parent/guardian: _____ Phone number: _____

Parent acknowledgement/action: (Detail if child picked up, etc.): _____

Signature of parent/guardian picking child up: _____

WITNESS(ES) (Please attach any supplemental pages as needed).

1. Name: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Witness description of the incident: _____

2. Name: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Witness description of the incident: _____

REPORT PREPARED BY:

Print Name [Employee]: _____ Position: _____

Signature [Employee]: _____ Date: _____

(Complete form and return to a Supervisor and the Town's Insurance Coordinator within 24 hours of incident).

ACCIDENT/INJURY REPORT The center shall maintain on file a written record of each incident resulting in an injury.		CENTER NAME:		CENTER ADDRESS:	
CHILD'S NAME:		PERSON COMPLETING REPORT:		WITNESS(ES):	
DATE OF INJURY:		TIME OF INJURY:		DATE REPORT COMPLETED:	
TYPE OF INJURY: (Check All That Apply)	<input type="checkbox"/> ACHE	<input type="checkbox"/> BREATHING SHALLOW	<input type="checkbox"/> FOREIGN BODY IN EYE	<input type="checkbox"/> REDNESS	
	<input type="checkbox"/> BITTEN BY ANIMAL	<input type="checkbox"/> BROKEN BONE SUSPECTED	<input type="checkbox"/> HEAD INJURY	<input type="checkbox"/> SCRAPE	
	<input type="checkbox"/> BITTEN BY CHILD	<input type="checkbox"/> CHOKING	<input type="checkbox"/> ITCHING	<input type="checkbox"/> SCRATCH	
	<input type="checkbox"/> BITE THAT BROKE THE SKIN	<input type="checkbox"/> CUT	<input type="checkbox"/> NAUSEA	<input type="checkbox"/> SPLINTER	
	<input type="checkbox"/> BLEEDING	<input type="checkbox"/> DROWSINESS	<input type="checkbox"/> NOSE BLEED	<input type="checkbox"/> SPRAIN	
	<input type="checkbox"/> BURN	<input type="checkbox"/> EYE INJURY	<input type="checkbox"/> POISONING	<input type="checkbox"/> STING	
	<input type="checkbox"/> BREATHING RAPIDLY	<input type="checkbox"/> FALL FROM A HEIGHT OF: _____	<input type="checkbox"/> RASH	<input type="checkbox"/> SWELLING	
	<input type="checkbox"/> OTHER:				
PLACE ON BODY INJURY OCCURRED: (Check All That Apply)	<input type="checkbox"/> ABDOMEN	<input type="checkbox"/> CHEEK	<input type="checkbox"/> FINGER	<input type="checkbox"/> HEAD	<input type="checkbox"/> MOUTH
	<input type="checkbox"/> ARM	<input type="checkbox"/> CHEST	<input type="checkbox"/> FOOT	<input type="checkbox"/> HIP	<input type="checkbox"/> NECK
	<input type="checkbox"/> ANKLE	<input type="checkbox"/> CHIN	<input type="checkbox"/> FOREHEAD	<input type="checkbox"/> KNEE	<input type="checkbox"/> NOSE
	<input type="checkbox"/> BACK	<input type="checkbox"/> EAR	<input type="checkbox"/> GROIN	<input type="checkbox"/> LEG	<input type="checkbox"/> SHOULDER
	<input type="checkbox"/> BUTTOCKS	<input type="checkbox"/> ELBOW	<input type="checkbox"/> HAND	<input type="checkbox"/> LIP	<input type="checkbox"/> TEETH
	<input type="checkbox"/> OTHER:				
WHERE INJURY OCCURRED: (Check All That Apply)	<input type="checkbox"/> CLASSROOM	<input type="checkbox"/> BATHROOM	<input type="checkbox"/> SIDEWALK	<input type="checkbox"/> CAR	<input type="checkbox"/> FIELD TRIP
	<input type="checkbox"/> HALLWAY	<input type="checkbox"/> STAIRWAY	<input type="checkbox"/> PARKING LOT	<input type="checkbox"/> BUS	<input type="checkbox"/> KITCHEN
	<input type="checkbox"/> OTHER:				
TYPE OF SURFACE	<input type="checkbox"/> CARPETING	<input type="checkbox"/> TILE FLOOR	<input type="checkbox"/> WOOD FLOOR	<input type="checkbox"/> RUBBER	<input type="checkbox"/> LAMINATE FLOOR
	<input type="checkbox"/> WOOD CHIPS	<input type="checkbox"/> GRASS	<input type="checkbox"/> SAND	<input type="checkbox"/> CONCRETE	<input type="checkbox"/> ASPHALT
	<input type="checkbox"/> OTHER:				
DESCRIBE HOW INJURY/ACCIDENT HAPPENED:					
TREATMENT/FOLLOW UP ACTIONS: (Check All That Apply)	FIRST AID GIVEN AT THE CENTER:			OUTSIDE MEDICAL ATTENTION GIVEN: (Notify the OOL by next working day and provide documentation within 1 week.)	
	<input type="checkbox"/> CLEANED WITH SOAP AND WATER	<input type="checkbox"/> CONSOLED CHILD	<input type="checkbox"/> MEDICATION ADMINISTERED:	<input type="checkbox"/> AMBULANCE OR 911 CALLED/ONSITE	
	<input type="checkbox"/> ICE APPLIED	<input type="checkbox"/> OTHER (DESCRIBE):	<input type="checkbox"/> EMERGENCY CARE PROVIDED		
	<input type="checkbox"/> ANTISEPTIC APPLIED		<input type="checkbox"/> POISON CONTROL CALLED		
	<input type="checkbox"/> REST PROVIDED		<input type="checkbox"/> TRANSPORTED EMERGENCY/URGENT CARE		
	<input type="checkbox"/> BANDAGE APPLIED		<input type="checkbox"/> CONSULTATION/TREATMENT BY LICENSED PHYSICIAN OR HEALTH CARE PROVIDER		
PARENT NOTIFICATION*:	METHOD OF NOTIFICATION:		TIME OF NOTIFICATION:	COMMENTS:	
	<input type="checkbox"/> NOTIFIED BY PHONE	<input type="checkbox"/> OTHER:			
	<input type="checkbox"/> NOTIFIED AT PICK UP				
* Take immediate necessary action to protect the child from further harm and immediately notify the child's parent(s) when a bite breaks the skin; a child sustains a head or facial injury, including when a child bumps his/ her head; a child falls from a height greater than the height of the child; or an injury requiring professional medical care occurs.					
STAFF SIGNATURE:	DATE:	DIRECTOR SIGNATURE:	DATE:	PARENT SIGNATURE:	DATE: