**STATE OF DELAWARE  
DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH AND THEIR FAMILIES  
OFFICE OF CHILD CARE LICENSING (OCCL)**

**ACCIDENT OR INJURY REPORT**

**INSTRUCTIONS:** Each accident/injury that occurs to a child while on the premises must be documented and a report must be provided to the parent/guardian/authorized release within one business day.  If a child receives medical or dental treatment, other than first aid provided by the facility, due to a known accident/injury that occurred while in the facility’s care, call OCCL within one business day to provide notification.  After this notification, submit the accident/injury report to OCCL within three business days.

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| Name of Facility or Provider | Telephone Number |
| Facility Address (Street, City, Zip Code) | County |
| Name of Injured Child Home Address (Street, City, Zip Code) Date of Birth  Sex: [ ] Male [ ] Female | |
| Name of Witness (if more than one, print on back) | Telephone |
| Accident or Injury | Accident Location, Date, and Time |
| Describe Accident or Injury | |
| Time & Date Parent/Guardian was notified, Method of contact and by whom  Message(s) left [ ] Time(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact by whom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| What caused the accident to happen? | What was the child doing? |
| What first aid was given and/or action taken? | |
| What corrective action was taken, if any, to prevent a similar occurrence in the future? (e.g. rug was removed) | |
| **For medical/dental treatment only: If provided by parent, attach the discharge papers upon the child’s return.** | |
| How was accident or injury diagnosed by physician? | Were any handicaps, health problems, or exceptions  listed on child’s health records? [ ] Yes [ ] No  If “yes,” please explain on back of form: |
|  | |
| Signature of Parent/Guardian/Authorized Release | Date |
| Signature of Person completing the form | Date |
| Signature of Administrator/Curriculum Coordinator/Owner | Date |