**STATE OF DELAWARE
DEPARTMENT OF EDUCATION
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  | License Number Telephone Number |
| Facility Address (Street, City, Zip Code)  | County |
| Name of Injured Child Home Address (Street, City, Zip Code) Date of BirthSex: [ ] Male [ ] Female |
| Names of Staff Present and/or Witnesses |  |
| Date & Time of Accident/Injury  | Location Where Accident/Injury Occurred  |
| Describe Accident/Injury (Type and Parts of Body Injured) |
| Name of Parent/Guardian Notified Time and Date Notified Method of contact and by whomMessage(s) left [ ] Time(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact by whom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| What caused the accident/injury to happen?  | What was the child doing? |
| What first aid was given at the facility 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 injury diagnosed by health care professional?  | Were any disabilities, health problems, or exceptions listed on child’s health records? [ ] Yes [ ] NoIf “yes,” please explain on back of form. |
|  |
| Signature of Parent/Guardian/Authorized Release  | Date  |
| Signature of Person completing this report  | Date |
| Signature of Licensee/Administrator/Designated Staff Member | Date |