

# ACCIDENT-INCIDENT REPORT/NESD HEAD START

Directions: **Respond to emergency at hand; Call 911 or Ambulance if needed. Check the injured child. Notify your supervisor of the incident immediately.**

Fill out **this form within 24 hours** and scan a copy to the **Health Manager**.

Complete the **Accident Follow-Up Form within 24-48 hours** and scan a copy to the **Health Manager**. Keep originals in child's file.

**If child receives medical treatment, Assist Parent with Completion of the "Child Accident-Medical Claim Form" from the website. *Scan completed form to Head Start Office.***

**Bills will be sent to The Hartford insurance company (not Head Start, Medicaid or Private Health Insurance). Staff where accident happened must inform the clinic/hospital of the Hartford Policy Number, and contact information.** Head Start Executive Director must be notified of claim.

NAME \_\_\_\_\_ CENTER/HOME BASE NAME \_\_\_\_\_

DATE OF ACCIDENT/INCIDENT \_\_\_\_\_

BRIEF DESCRIPTION OF WHAT HAPPENED: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

WITNESSES \_\_\_\_\_

IMMEDIATE TREATMENT GIVEN OR ACTION TAKEN (if none, please indicate): \_\_\_\_\_

\_\_\_\_\_

Was parent notified? \_\_\_\_\_ Time \_\_\_\_\_ Date \_\_\_\_\_ By whom? \_\_\_\_\_

Was Physician notified? \_\_\_\_\_ **Physician & Clinic/Hospital** \_\_\_\_\_

Describe Injury (ie: cut, bruise, etc) \_\_\_\_\_

\_\_\_\_\_

Were other individuals involved? Who? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ **Please check after you notify your Supervisor. Time/date notified:** \_\_\_\_\_

\_\_\_\_\_ **Please check after you notify the Health Manager.**

PERSON MAKING OUT REPORT \_\_\_\_\_

(Signature)