ACCIDENT-INCIDENT REPORT/PARENT FOLLOW-UP
NESD HEAD START

(TO BE COMPLETED 24 - 48 HOURS AFTER ACCIDENT)

Date: ____

Date of accident:____

Name of child:____

Center/Home Base____

Name of contact person called:____

Further treatment at home:____
____
____

Any problems today? ____ Yes ____ No

Explain: ____
____
____

Was treatment required? ______ Yes ______ No

Explain: ____

____

Place of Treatment:____
(Hospital, clinic, community health)

***If medical treatment was received, see the Child Accident Procedure & complete the Child Accident-Medical Claim form.**

Does parent request further treatment? ____ Yes ____ No

If yes, state treatment: ____

If no, state reason: ____

Signature:____
Teacher/Home Visitor

*Send a copy of this form to the Health Services Coordinator
12/12