

**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/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