

Incident or Illness Report

Operations use this form to record all required information when a child sustains an injury, at the onset of an illness or reportable incident.

Directions

Complete the form as follows:

- **Injury requiring medical treatment or hospitalization:** Complete all information in Sections I, II, V and VI.
- **Incident that places, or may place, a child at risk for injury or harm:** Complete all information in Sections I, II, V and VI.
- **Illness requiring hospitalization:** Complete all information in Sections I, III, V and VI.
- **Incidence of a child or employee contracting a communicable disease:** Complete all information in Sections I, IV, V and VI.

After completing the form:

- notify parents as required by the minimum standards; and
- keep the form on file at the operation.

Privacy Statement

HHSC values your privacy. For more information, read the privacy policy online at: <https://hhs.texas.gov/policies-practices-privacy#security>.

Section I – General Information

Director's Name:	Operation No.:	Date of Incident or Illness:	Time of Incident or Illness: <input type="radio"/> a.m. <input type="radio"/> p.m.
Parent(s)* Notified: <input type="radio"/> Yes <input type="radio"/> No <small>*For communicable diseases, all parents must be notified.</small>	Date:	Time:	By:
Child Care Regulation Notified: <input type="radio"/> Yes <input type="radio"/> No	Date:	Time:	By:

Section II – Details of Injury or Incident *(Section not used for incidences of communicable disease or illnesses.)*

Child's Full Name:	Child's Date of Birth:	Caregiver in Charge:
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
Describe the injury or risk:		
<input style="width: 100%; height: 100%;" type="text"/>		
How did the incident or injury occur?		
<input style="width: 100%; height: 100%;" type="text"/>		
Additional staff present or witness to the incident or injury:		
<input style="width: 100%; height: 100%;" type="text"/>		
Was first aid provided? <input type="radio"/> Yes <input type="radio"/> No What type of first aid was provided? _____		
Was Emergency Medical Services (EMS) called? <input type="radio"/> Yes <input type="radio"/> No Time EMS was called: _____		
Was child transported to receive medical care? <input type="radio"/> Yes <input type="radio"/> No Who transported the child? _____		

Section III – Illness Requiring Hospitalization (Section *not* used for incidents, injuries or notifications communicable disease.)

Child's Full Name: Child's Date of Birth:

Was first aid provided? Yes No What type of first aid was provided? _____

Was medication given? Yes No Name of medication: _____ Dosage: _____

Did the child have a fever? Yes No Temperature: _____

Was medical treatment required? Yes No Date and time medical treatment received: _____

Was EMS called? Yes No Time EMS was called: _____

Was child transported to receive medical care? Yes No Who transported the child? _____

Was an allergy plan enacted? Yes No N/A What was done? _____

Was there an emergency anaphylaxis reaction that required administration of an unassigned epinephrine auto-injector? Yes No

Was use of an unassigned epinephrine auto-injector reported to Texas Department of State Health Services (DSHS)? Yes No N/A

Date reported to DSHS: _____

Was the child's doctor called by the operation? Yes No

Doctor's Name: Doctor's Phone No.: Time doctor was called:

Doctor's recommendation(s):

Did the child see his or her doctor? Yes No Diagnosis or Outcome: _____

Was hospitalization required? Yes No Additional Details: _____

Section IV – Communicable Disease (Section *not* used for incidents, injuries or illness other than communicable disease notification.)

Type of communicable disease contracted by child or employee at this operation:

Does the communicable disease require exclusion? Yes No

Was the Health Department notified? Yes No Date Health Department notified: _____

Section V – Employee or Caregiver Certification

I verify that I, the director or person in charge, reviewed the information in this report.

Printed Name: _____ Signature of Director or Person in Charge: _____ Date Signed: _____

Section VI – Parent or Guardian Acknowledgment

I verify that the operation appropriately relayed the information concerning the incident described in this report. I have received a copy of this report. (If emailed or distributed electronically, you may attach a copy of the method used.)

Printed Name: _____ Signature of Parent or Guardian: _____ Date Signed: _____