

INCIDENT INFORMATION REPORT

Name of incident party _____ D.O.B. _____ Gender _____

Address _____ City, St. _____ Zip _____

Phone # _____ Guardian contacted at # _____

Nature of Incident:

Name of witness(es) (if any): _____ Phone _____

Witness Statement _____

Name, Address and phone number of Hospital or treatment facility: _____

Treatment or action taken: _____

If x-rays were taken, were they obtained for parental use? _____

Medication dispensed due to the accident:

Date: _____ Time: _____ Dosage: _____ By whom? _____

Date: _____ Time: _____ Dosage: _____ By whom? _____

Date: _____ Time: _____ Dosage: _____ By whom? _____

Called Parent: Date _____ Time _____

Comments on conversation: _____

Special instructions given by parent for treatment of child: _____

Name and phone # of person filing this report: _____

Date _____ [Use back side of this form for further comments and "follow up" information]

FOLLOW UP REPORT

DATE:

WAS GUARDIAN NOTIFIED? IF SO, WHO?

IF NOT, WHY?

WAS PERSON ADMITTED TO HOSPITAL?:

WHAT HOSPITAL?:

ADDRESS:

PHONE:

WAS 'FOLLOW-UP' VISIT OR CALL MADE?:

WHEN?:

BY WHOM?:

DOES THIS INCIDENT NEED TO BE REPORTED TO OUR INSURANCE?:

IF SO, WHEN?:

COMMENTS:

PERSON FILING REPORT:

POSITION: