



early childhood specialists
losninos.com

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INCIDENT REPORT FORM

Child's Name: _____ EI/CPSE #: _____

Child's DOB: _____ Date of Incident: _____ Time of Incident: _____

Specific Location of Incident (ie. Child's home, living room of babysitter's apartment, cafeteria, etc):

PARTICIPANTS:

Child's Name: _____

Clinician: _____

Caregiver: _____

Others (SC, family members, visitors, etc.) : _____

DESCRIPTION of the INCIDENT: (How did the incident/accident happen? Where were the participants at the time of the incident? What were the participants doing? Specify any equipment or tools that were being used.) _____

IMMEDIATE ACTION TAKEN:

___ Caregiver instructed to see physician or take child to emergency room.

___ Service Coordinator notified.

Will caregiver accept further care from therapist involved? ___ YES ___ NO

Individuals Notified:

___ Service Coordinator/Case Manager ___ Nurse ___ Human Resources ___ Clinical Manager of QA

Person Completing this report (print name): _____

Signature: _____

Title: _____

Date: _____

Follow-Up, as needed (to be filled in by Nurse Administrator): _____

