**College of Southern Idaho Head Start/ Early Head Start**

Incident Report – Non-Staff

(Fax a copy to Central Office after the incident and mail original within 24 hours to CO, Place a copy at the center)

**Name of Injured Party** _____ □ Head Start Child □ Other

Address of Injured Party _____

Name of Parent/Guardian *(if applicable)* _____

Date Incident occurred _____ Time _____ a.m. or p.m.

What type of product or equipment was involved in the incident, if any? _____

_____

Describe in detail how the incident happened (Specify what was injured): _____

_____

_____

Location of incident *(address)*: _____

Was first aid administered? (Describe): _____

_____

_____

Action taken by medical personnel, if required: _____

_____

_____

Diagnosis/Follow-up Plan: _____

_____

_____

Corrective action needed to prevent reoccurrence: _____

_____

_____

Supervisor's Signature _____ Date _____

Witnesses: Name _____ _____

Address _____ _____

_____ _____