



Nunatsiavut Dept. of Health and Social Development

Incident/Injury Report

Name of Child Care Centre: _____

Child's Name: _____ Age: _____ Date: _____

Time of Accident: _____

List staff Present _____ Number of Children _____

Description of Incident/injury:

Was First Aid given: Describe:

Who Administered First Aid? _____

Check all that apply

Location

- | | | |
|--------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Bathroom | <input type="checkbox"/> Playground | <input type="checkbox"/> Stairway |
| <input type="checkbox"/> Hallway | <input type="checkbox"/> Preschool room | <input type="checkbox"/> Toddler room |
| <input type="checkbox"/> Infant room | <input type="checkbox"/> School-Age room | <input type="checkbox"/> Walkway |

Markings

- | | | | |
|-----------------------------------|-------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Abrasion | <input type="checkbox"/> Bump | <input type="checkbox"/> Red Mark | <input type="checkbox"/> Sprain
(suspected) |
|-----------------------------------|-------------------------------|-----------------------------------|--|

- | | | | |
|---------------------------------|---|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Bite | <input type="checkbox"/> Cut/Tear | <input type="checkbox"/> Rug Burn | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Bruise | <input type="checkbox"/> Fracture (suspected) | <input type="checkbox"/> Scratch | |

Body part

- | | | | | | |
|---------------------------------------|----------------------------------|-----------------------------------|-------------------------------|-----------------------------------|---------------------------------|
| <input type="checkbox"/> Left | <input type="checkbox"/> Buttock | <input type="checkbox"/> Eye | <input type="checkbox"/> Heel | <input type="checkbox"/> Neck | <input type="checkbox"/> Teeth |
| <input type="checkbox"/> Right | <input type="checkbox"/> Cheek | <input type="checkbox"/> Finger | <input type="checkbox"/> Hip | <input type="checkbox"/> Nose | <input type="checkbox"/> Toe |
| <input type="checkbox"/> Ankle | <input type="checkbox"/> Chin | <input type="checkbox"/> Forehead | <input type="checkbox"/> Knee | <input type="checkbox"/> Penis | <input type="checkbox"/> Tongue |
| <input type="checkbox"/> Arm | <input type="checkbox"/> Ear | <input type="checkbox"/> Hand | <input type="checkbox"/> Leg | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Vagina |
| <input type="checkbox"/> Back | <input type="checkbox"/> Elbow | <input type="checkbox"/> Head | <input type="checkbox"/> Lips | <input type="checkbox"/> Stomach | <input type="checkbox"/> Wrist |

Notification

Parent Called - Time: _____

By whom: _____

Was any further action taken?
i.e child sent to clinic? Or taken home?

Any Comments:

Staff's Signature: _____ Date: _____

Parent's Signature: _____ Date: _____

Note: One copy put in child's file. One copy provided to Parent . Licensed centres must send copy to Regional Child Youth and Family Services worker. If applicable- send a copy to Child Protection Services.