



CHILD CARE INJURY REPORT (MEDICAL ATTENTION NEEDED)

State Form 54265 (R / 7-14)

Return to:
**OFFICE OF EARLY CHILDHOOD AND
OUT OF SCHOOL LEARNING**
CHILD CARE LICENSING – MS02
402 West Washington Street, Room W361
Indianapolis, Indiana 46204

The information in this document is confidential.

Name of provider		Date of injury (month, day, year)	Time of injury	Did the injury result in death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Address of provider (number and street, city, state, and ZIP code)				
Telephone number ()		License / Registration / Provider Electronic Solutions (PES) number		
Name of child		Age	Sex	
Name of parent			Telephone number ()	
Address of parent (number and street, city, state, and ZIP code)				
Was the injury caused by a fall? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, type of surface:		
Did the injury occur on playground equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, type of equipment:		
Briefly describe how the injury happened. ----- -----				
Location where the injury occurred				
Name of witness to the injury			Child to staff ratio at the time of the injury	
Was the child given first aid? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, by whom:		
Type of first aid given				
Were the parents notified? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, by whom:		If yes, when:
Was emergency treatment provided at the hospital / doctor's office / dentist? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, where:		
Result of injury (diagnosis / treatment) ----- -----				
Corrective action taken to prevent further injuries ----- -----				
Signature of provider			Date (month, day, year)	