

Child's Name <i>surname</i> <i>first name</i>		Child's I.D. Number
Agency/Program/Foster Parents		Birthdate (yyyy/mm/dd)
Name of Person Completing Report		Position/Title
Date of Incident (yyyy/mm/dd)	Time of Incident	Location of Incident
Who was involved/Witness(es)		

Type of Incident (check off as many as apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Threat of Self Harm/Suicide Attempt | <input type="checkbox"/> Use of Physical Restraint | <input type="checkbox"/> Death |
| <input type="checkbox"/> Serious change in the child's health | <input type="checkbox"/> Severe Acting Out | <input type="checkbox"/> Violence |
| <input type="checkbox"/> Injury to the child | <input type="checkbox"/> Confinement | <input type="checkbox"/> Destruction |
| <input type="checkbox"/> Charges/Offences | <input type="checkbox"/> Accident | <input type="checkbox"/> Drug/Alcohol Abuse |
| <input type="checkbox"/> Fire | <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> Unplanned Discharge |
| <input type="checkbox"/> Allegation of Abuse/Neglect | <input type="checkbox"/> Error in administration of prescribed medication to the child | <input type="checkbox"/> Adverse reaction to medication |
| <input type="checkbox"/> Isolation | | <input type="checkbox"/> AWOL |
| <input type="checkbox"/> Other, please specify _____ | | |

Description of incident and action taken:

Recommendations for further action:

Recommendations for charge in policy/procedures:

People Contacted (check off as many as apply)

- | | | |
|--|--------------------------------------|--|
| <input type="checkbox"/> Agency Director | <input type="checkbox"/> Police | <input type="checkbox"/> Therapist |
| <input type="checkbox"/> Client's Family | <input type="checkbox"/> Crisis Unit | <input type="checkbox"/> Probation |
| <input type="checkbox"/> Licensing Officer | <input type="checkbox"/> Caseworker | <input type="checkbox"/> Intervention Services Supervisor/District Manager |
| <input type="checkbox"/> Client's Legal Guardian | | |
| <input type="checkbox"/> Other, please specify _____ | | |

Signatures

Name of Child Care Worker/Foster Parent (please PRINT)	Signature of Child Care Worker/Foster Parent	date (yyyy/mm/dd)
Name of Program Supervisor/Director (please PRINT)	Signature of Program Supervisor/Director	date (yyyy/mm/dd)