

South Central Child Development, Inc.
INCIDENT REPORT
File copy in Central Office Immediately!!

Name of Person Submitting Report: _____

1. Name of Injured _____ Sex M F School Grade _____
Birthdate ____/____/____ Social Security Number ____/____/____

2. Address of Injured _____
Mailing Address _____ City _____ State _____ Zip _____

3. Date and Time of Accident Date _____ Time _____ A.M. _____ P.M. _____

4. What injuries were received? _____

5. Where did the accident take place? _____

6. How did the accident take place? **(Be specific, explain exactly what happened)**

7. Did the accident occur:

While taking part in an activity sponsored and directly supervised by the plan sponsor.

Describe type of activity involved _____

During direct travel to or from the meeting place to take part in a program sponsored activity.

Name of Supervisor _____ Title _____

Phone _____

Was the person checked by: Doctor _____ Nurse _____

If so, request written results, treatment etc., and obtain signature below

Signature and Title _____ Date _____

If a Minor Father's Employer (Name and Address) _____

Mother's Employer (Name and Address) _____

I certify that the above information is true and correct.

Signature of Injured _____ Date _____ Phone(____) _____

Parent or Guardian if Minor

Signature of Witness _____ Date _____ Phone(____) _____