CCL. 028a
12/2019

Kansas Department of Health and Environment
Bureau of Family Health
Child Care Licensing Program
1000 SW Jackson Street, Suite 200
Topeka, KS 66612-1274
Phone: (785) 296-1270 Fax: (785) 559-4244
Website: www.kdheks.gov/kidsnet

Critical Incident Report

*This form, for License and Group Day Care Homes, Child Care Centers and Preschools, and School Age Programs is to be used when reporting an injury, death, critical incident or occurrence that jeopardizes the safety of any child in care pursuant to K.A.R. 28-4-133 and K.A.R. 28-4-592. *This form may be used for Drop in Programs reporting to KDHE.*

Name of Facility (exactly as it appears on the license):	License #	Date Completed:
Street Address of Facility:	City and County:	

Section 1: Type of Notification

Indicate type of report:

____Injury ____Death ____Vehicle Collison ____Fire ____Missing Child ____Other (identify)_____

Date of Incident:_____ Time of Incident: _____

Section 2: Individuals Involved in the Incident

First and Last Name of Child(ren) or Adult:	Sex:	Date of Birth:

Section 3: Adult(s) Providing Supervision

Adult(s) responsible and/or observing the incident:	Affiliation to the Facility: (staff member, volunteer, observer, etc.)

Section 4: Incident Details

Incident Occurred On/In:

_____Classroom _____Playground_____Gym _____Stairs_____Hallway_____Kitchen_____Living Room

_____Gym_____Bathroom_____Bedroom_____Outside Play Area Other:_____

Was playground equipment involved in injury? ____Yes____No
Was there any apparent malfunction of equipment? ____Yes____No
Was the equipment age appropriate? ____Yes____No

Incident involved:

____Collision with person ____Exposure to cold/heat ____Collision with obstacle ____Bitten by Child ____Eating or choking
____Insect sting/bite ____Hit or pushed by child ____Animal bite ____Fall from running or tripping
____Vehicle ____Fall to surface; estimated height of fall____feet; type of surface: _____

Other: _____

Body part injured: Please indicate left, right or both if applicable

Head		Trunk	Extremities	
____Ear	____Scalp/Head	____Abdomen	____Hand	____Foot
____Eye	____Teeth	____Back	____Finger	____Toes
____Face	____Neck	____Chest	____Thumb	____Ankle
____Tongue		____Shoulder	____Wrist	____Hip
		____Groin	____Arm	____Knee
			____Leg	

Other: _____

Critical Incident Details (be specific):

_____

_____

_____

_____

_____

_____

Section 5: Action Taken and Comments

____CPR was administered by program staff ____First Aid was administered by program staff ____EMS (911) was called
____Parent took child to doctor/clinic ____Parent took child to ER ____Parent took child home Other: _____

Section 6: Corrective Action Taken to Prevent Reoccurrence and/or Comments:

_____

_____

_____

_____

_____

_____

Section 7: Parent/Guardian Notification

Name of Person Notified: _____ Date and Time of Notification: _____

I attest that to the best of my knowledge, the information provided on this form is true and correct.

Print First and Last Name of Primary Care Provider/Program Director Completing this Form:	
Signature:	**Date Signed (MM/DD/YYYY)**

SUBMIT FORM ONE OF THE FOLLOWING WAYS (PLEASE SUBMIT ONLY ONE TIME)

Email- kdhe.cclr@ks.gov
Mail: 1000 SW Jackson, Suite 200, Topeka, KS 66612
Fax- [785] 559-4244