

**SONCCA
ACCIDENT REPORT: CHILD**

Description

Date of Accident _____ Time: _____ AM
PM

Name of Injured: _____ Site: _____

Detailed Description of Accident (Location of Incident, Origin & Cause, Contributing Factors):

Detailed Description of Injury:

Accident Management

First Aid Required: Yes No First Aid Provided: Yes No

Detailed Description of First Aid Provided:

Were Protective Gloves Worn? Yes No

Witnessed by: _____

Was employee exposed to blood or other potentially infectious material? Yes No

If Yes, Print Name(s) of Employees: _____

Did Child Continue Activities? Yes No

Was the Child Transported? Yes No

If yes, where?: Home Hospital/Clinic Physician's Office

Physician's Name: _____ Address: _____

Parent/Guardian Notification

When & Where: _____ Date: _____ Time: _____ AM
PM

Parent/Guardian Signature: _____ Date: _____

Report Submitted By: Employee Name: _____

Position: _____ Date: _____