ACCIDENT-INCIDENT REPORT/PARENT FOLLOW-UP
NESD HEAD START

(TO BE COMPLETED **24 - 48 HOURS** AFTER ACCIDENT)

Date: _____

Date of accident:_____

Name of child:_____Center/Home Base Name_____

Name of contact person called:_____

Further treatment at home:_____
_____
_____

Any problems today? ____ Yes ____ No

Explain: _____
_____
_____

Was treatment required? _____ Yes _____ No

Explain: _____

_____

Place of Treatment:_____

(Doctor, Clinic, Hospital)

If child receives medical treatment, Assist Parent with Completion of the "Child Accident-Medical Claim Form" from the website. *Scan completed form to Head Start Office*.
Bills will be sent to The Hartford insurance company (not Head Start, Medicaid or Private Health Insurance). Staff where accident happened must inform the clinic/hospital of the Hartford Policy Number, and contact information. Head Start Executive Director must be notified of claim.

Does parent request further treatment? ____ Yes ____ No

If yes, state treatment: _____

If no, state reason: _____

Signature:_____
Teacher/Home Visitor

*Send a copy of this form to the Health Manager