

ACCIDENT REPORT FORM

CLAY COUNTY DAY CARE

DATE: _____

DAY CARE PROVIDER: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

CHILD(REN) INJURED: _____

NATURE OF INJURY: _____

DATE OF INJURY: _____

MEDICAL TREATMENT REQUIRED? YES NO

IF YES, LIST DOCTOR AND/OR HOSPITAL, IF KNOWN: _____

PARENTS OF CHILD NOTIFIED? YES NO

PARENT'S NAME: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

Signature of Day Care Provider

Signature of Parent

* Please return this form to Clay County Licensors within 24 hours of injury.