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Curtis State Office Building
Kansas Department of Health and Environment
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Phone: 785-296-1270 | Fax 785-559-4244
Email: kdhe.cclr@ks.gov | kdhe.ks.gov/ChildCareLicensing

Kansas Department of Health and Environment

Critical Incident Report

*This form, for Family Child 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:_____

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

____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:_____

Indicate the body part injured: Please mark left (L), right (R), or both (B) 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 Person Completing this Form:	
Signature:	**Date Signed (MM/DD/YYYY)**

Submit Form one of the following ways: (Please submit only one at a time)

- Email: kdhe.cclr@ks.gov Subject: Critical Incident, Name of Facility, License # of Facility
- Mail: 1000 SW Jackson, Suite 200, Topeka, KS 66612
- Fax: [785] 559-4244