

**STATE OF DELAWARE  
DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH AND THEIR FAMILIES  
OFFICE OF CHILD CARE LICENSING**

**ACCIDENT OR ILLNESS REPORT**

**INSTRUCTIONS:** The Provider shall report to the Department of Services For Children, Youth and Their Families any serious accident or illness requiring hospital care or death which occurs while the facility is in operation.

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Name of Facility or Provider Telephone Number

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Facility Address (Street, City, Zip Code) County

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Name of Injured Child or Adult Home Address (Street, City, Zip) Age Sex  
( ) Male ( ) Female

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Name of Witness (If more than one, print on back) Telephone

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Accident or Illness Where Did Accident Happen?  
(Date) (Time)

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Describe Injury or Illness

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What caused the accident to happen? What was the child doing?

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What First Aid was given and/or action taken?

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How was injury or illness diagnosed by physician? Were any handicaps, health problems or exceptions listed on child's health records? ( ) Yes ( ) No  
If "yes," explain:

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Name of Diagnosing Physician

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If Fatality, Cause of Death

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Local Medical Examiner Notified Autopsy Performed  
( ) Yes ( ) No ( ) Yes ( ) No

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After thinking about the accident/illness, is there any action you would suggest to prevent it from happening again?

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Signature of person completing report Title Date

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Signature of Provider or Operator Date