Texas Dept of Family
and Protective Services

INCIDENT/ILLNESS REPORT

Form 7239
July 2007

Fill in all appropriate areas. Use additional sheets as necessary.

Caregiver in Charge of Child	Operation Name	Operation ID #	Time Parent Notified ☐am ☐pm
Child's Name	Date of Birth	Licensing notified? (if required) ☐Yes ☐No Date/Time Person's name	
Child's Address	Date of Incident/Illness	Time of Incident/Illness ☐am ☐pm	
Place of Incident			
Parent's Name	Parent's Telephone	Date Parent Notified	
Did the child see his/her doctor? ☐Yes ☐No If so, fill out information below:	Was First Aid Provided? ☐Yes ☐No What was done?	Was medical attention required? ☐Yes ☐No	Was EMS called? ☐Yes ☐No Time called ☐am ☐pm Time responded ☐am ☐pm
Child's Doctor	Doctor's Address	Doctor's Phone #	Doctor called ☐ yes (time) ☐ no
Doctor's Diagnosis or Instructions			Date/Time Consulted ☐am ☐pm

A. Details of Incident That Caused Injury or Placed Child at Risk:

Describe injury or risk in which child was placed:
Where and how did the incident/injury occur?
Staff who witnessed the incident/injury.
Other staff who were present at the time of the incident/injury.

B. Details of On-set of Illness While in Care

Type of Illness	Does the illness require exclusion from care? ☐Yes ☐No
If communicable: other parents notified? ☐Yes ☐No Method used:	Health Dept. notified? ☐Yes ☐No Date
Temperature of Child	Medication given

I verify that the above information is a true and accurate account of the incident/injury that occurred concerning this child.

____ _______________________________________

Signature of Director/Person in Charge Date Signed

I verify that the director/person in charge appropriately relayed the information concerning the incident/injury concerning my child. I have received a copy of this report.

____ _______________________________________

Signature of Parent Date Signed