APPENDIX H Rev. 02/05/08

INCIDENT REPORT

FOSTER HOME:_____
ADDRESS:_____
CITY:_____
DATE OF INCIDENT:_____ **TIME OF INCIDENT:**_____AM/PM
DATE REPORTED TO MCCS:_____

FOSTER CHILD(REN) INVOLVED:_____ **AGE:**_____
_____ **AGE:**_____
_____ **AGE:**_____

OTHER PERSONS INVOLVED:
NAME:_____ **RELATIONSHIP:**_____
NAME:_____ **RELATIONSHIP:**_____
NAME:_____ **RELATIONSHIP:**_____
(Please indicate whether other persons involved are members of the foster home)

LOCATION OF INCIDENT:
☐ Foster Home ☐ School ☐ Agency ☐ Other, specify: _____

TYPE OF INCIDENT (Check all that apply):
☐ Accidental Injury
☐ Self-Inflicted Injury
☐ AWOL (more than 24 hrs)
☐ Use of Restraint (NO INJURY)
☐ Youth Injured During Restraint
☐ Youth Became Violent
☐ Youth Fighting
☐ Youth Threatened Other(s); Name(s):_____
☐ Youth Injured Other(s); Name(s):_____
☐ Property Damage/Loss, specify:_____
☐ Youth Committed Criminal Act, specify:_____
☐ Unintentional Drug/Substance Overdose, specify drug/substance:_____
☐ Intentional Drug/Substance Overdose, specify drug/substance:_____
☐ Other, specify:_____
☐ Youth Threatened Suicide
☐ Youth Attempted Suicide
☐ Youth Committed Suicide
☐ Accidental Death
☐ Death by Natural Causes
☐ Suspicious/Unusual Cause of Death

TYPE OF INJURY (Check all that apply):
☐ None ☐ Bite ☐ Bruise
☐ Burn ☐ Swelling ☐ Sprain
☐ Possible Fracture/Dislocation
☐ Fracture/Break
☐ Other, specify: _____

DESCRIPTION OF INCIDENT/CAUSE OF INJURY:

_____

_____

_____

_____

_____

ACTION(S) TAKEN (Check all that apply):

- ☐ Youth Taken to Hospital by Squad
- ☐ Youth Taken to Hospital by Foster Parent/Caretaker
- ☐ Youth Treated by Family Doctor
- ☐ Emergency Counseling Appointment
- ☐ Youth Treated by Paramedics
- ☐ Youth Treated in Emergency Room
- ☐ Youth Treated by Foster Parent
- ☐ Youth Treated by Other; specify_____
- ☐ Youth Admitted to Hospital
- ☐ Youth Admitted to Psychiatric Unit
- ☐ Youth Arrested
- ☐ Youth Placed in Juvenile Detention
- ☐ None

RESULTS OF ACTIONS TAKEN:

_____

_____

_____

_____

FURTHER ACTION(S) REQUIRED?: ☐ NO ☐ YES (explain):

_____

_____

_____

_____

PERSONS/AGENCIES CONTACTED (Check all that apply):

- ☐ IMPRINT Coordinator
- ☐ Placement Caseworker
- ☐ Law Enforcement
- ☐ Primary Family/Guardian
- ☐ Youth's Caseworker
- ☐ Hospital
- ☐ ER/Paramedic Squad
- ☐ Fire Dept
- ☐ Mental Health Ctr.
- ☐ Mental Health Therapist
- ☐ Mental Health Case Manager
- ☐ Family Doctor
- ☐ Other, specify: _____

***FORM COMPLETED BY:**_____DATE:_____

***RELATIONSHIP TO CHILD**:_____

***DATE CW NOTIFIED PARENT (S) OF INCIDENT IF CHILD IS NOT IN THE PERMANENT CUSTODY OF THE AGENCY**_____

* Copies within 24 hours of the incident to:

- MCCS Director date provided:_____
- Ongoing Supervisor date provided:_____
- Placement Supervisor date provided:_____
- Placement/IMPRINT CW date provided:_____
- Caseworker/child file date provided:_____

To Be Completed By Placement Supervisor:

☐ General Incident ☐ Critical Incident

Signature:_____ Date:_____