Colorado State Department of Human Services
1575 Sherman Street
Denver, Colorado 80203

INJURY, ACCIDENT, ILLNESS OR FATALITY REPORT

To be filled in by a foster/kin home parent in case of accident or injury occurring to foster/kin child resulting in medical treatment, hospitalization or death, and submitted to the licensing or certifying agency immediately following the occurrence.

Name of foster/kin parent reporting _____
Address _____ City _____
Name of child _____ Age _____

Name of Individual or Agency with legal custody of child _____

Address _____ City _____

Witness to Accident _____

Address _____

Please explain the type and the circumstances of the child's accident or injury; include date, time and location (use the back of the form, or additional sheets if necessary)

_____

_____

_____

_____

Describe any action taken or treatment given to child in the home _____

_____

_____

Treatment given by _____

Attending Physician's Name (if any) _____

Hospital, clinic or other treatment facility to which the child was taken _____
_____ Address _____

☐ Check if child is still there.

How was the child transported to the hospital or clinic _____

If the foster homes' insurance was utilized, give name and address of insurance company. _____

_____

_____

_____
Signature of foster/kin home parent

_____
Date