



INCIDENT FORM

CLAY COUNTY FOSTER CARE

DATE: _____

FOSTER CARE PROVIDER: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

DATE OF INCIDENT: _____

CHILD (REN) INVOLVED: _____

WHERE DID INCIDENT HAPPEN: _____

WHO ELSE WAS THERE: _____

WHAT HAPPENED: _____

MEDICAL TREATMENT REQUIRED: YES NO

IF YES, LIST DOCTOR AND/OR HOSPITAL, IF KNOWN: _____

CHILD'S WORKER NOTIFIED? YES NO

WORKER'S NAME: _____

Signature of Provider

Date

* Please return this form to Clay County Licensor within 24 hours of injury.