Firm Foundation, Inc
705 Cumberland Street
Fayetteville, NC 28301
(910) 485-3332

Date Report Completed:

INCIDENT REPORT

All questions contained in this questionnaire are stricly confidential. Complete this report within 24 hours of the incident. Please report the incident to the agency immediately.

Child's Name (*Last, First, M.I.*):

Male ☐ **Female** ☐

Location of Incident(*Complete Address*):

Name of Person Completing Form:	**Date Incident Occured:**

INCIDENT DETAILS

Time of Incident: ☐ **AM** ☐ **PM**

Incident:

☐	Medication Refusal	☐	Client Injury
☐	Runaway	☐	Property Damage
☐	Hospital	☐	Physical Aggression

Please provide a complete description of the Incident. Describe how the incident occured?

What were the consequences of the incident?

What actions were taken to prevent reoccurance?

If medication was refused, list the prescribed drugs and over-the-counter drugs of medication refused.

Name of Drug	Dosage	Frequency Taken

If the police were contacted as a result of this incident please complete the following section. *Please retreive and attach police report to this incident report.*

Police Name	Police Badge Number	Contact Date	

If the child transported to the hospital as a result of the incident please complete the following section. *Please retrieve and attach discharge paperwork from the hospital.*

Hospital Name	Contact Number	Transport Date:

Was the child admited to the hospital? **Yes:** ☐ **No:** ☐

Was the child's guardain/Social Worker contacted? **Yes:** ☐ **No:** ☐

Guardian Name/Contact Information	Contact Date:

Was a Firm Foundation staff contacted? **Yes:** ☐ **No:** ☐

Firm Staff /Contact Information	Contact Date:

Witnessess Names (if any)

Name	Role/Contact Information

Signature **Date**