

Incident, injury, trauma and illness record

Details of person completing this record

Name			
Position/role			
Service name			
Date record was made	Time record was made		
			[] am [] pm
Signature			
	<i>Jane Citizen</i>		

Child details

Child's full name			
Date of birth	Age	Gender	
		[] Female [] Male	

Incident/injury/trauma/illness details

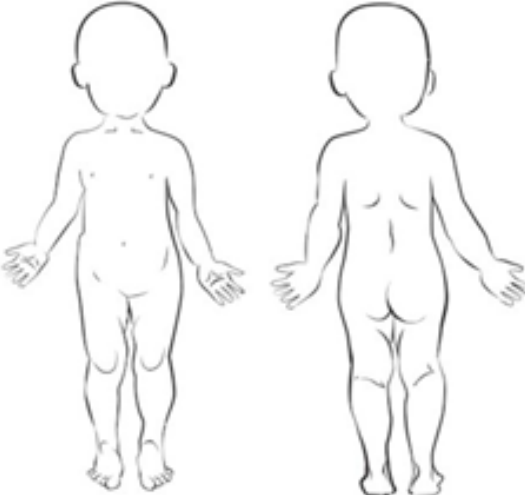
Incident/injury/trauma/illness	Date	Time	
		[] am [] pm	
Location of service			
Location of incident/injury/trauma/illness			
Name of person who witnessed the incident/injury/trauma/illness			
	Witness signature	Date	
	<i>Jindi Harris</i>		
Details of incident/injury/trauma/illness			

Circumstances leading to the incident/ injury/trauma/illness, including any apparent symptoms

Circumstances if child appeared to be **missing** or otherwise unaccounted for (incl. duration, who found child, etc.)

Circumstances if child appeared to have been **taken or removed** from service or was **locked in/out** of service (incl. who took the child, duration)

Nature of injury/trauma/illness:

 <p style="text-align: center;"><i>Indicate the part of the body affected on this diagram</i></p>	<input type="checkbox"/> Abrasion / scrape <input type="checkbox"/> Allergic reaction (not anaphylaxis) <input type="checkbox"/> Amputation <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Asthma / respiratory <input type="checkbox"/> Bite wound <input type="checkbox"/> Bruise <input type="checkbox"/> Broken bone / fracture / dislocation <input type="checkbox"/> Burn / sunburn <input type="checkbox"/> Choking <input type="checkbox"/> Concussion <input type="checkbox"/> Crush / jam <input type="checkbox"/> Cut / open wound <input type="checkbox"/> Drowning (non-fatal) <input type="checkbox"/> Electric shock <input type="checkbox"/> Eye injury	<input type="checkbox"/> Infectious disease (incl. gastrointestinal) <input type="checkbox"/> High temperature <input type="checkbox"/> Ingestion / inhalation / insertion <input type="checkbox"/> Internal injury / infection <input type="checkbox"/> Poisoning <input type="checkbox"/> Rash <input type="checkbox"/> Respiratory <input type="checkbox"/> Seizure / unconscious/ convulsion <input type="checkbox"/> Sprain / swelling <input type="checkbox"/> Stabbing / piercing <input type="checkbox"/> Tooth <input type="checkbox"/> Venomous bite / sting <input type="checkbox"/> Other (please specify)
--	---	---

Action Taken

Details of action taken (including first aid, administration of medication, etc.)

Did emergency services attend?	Time emergency services contacted	Time emergency services arrived
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> am <input type="checkbox"/> pm	<input type="checkbox"/> am <input type="checkbox"/> pm

Was medical attention sought from a registered practitioner / hospital?
 Yes No

If yes to either of the above, provide details

Have any steps been taken to prevent or minimise this type of incident in the future? If yes, provide details.

--

Notifications (including attempted notifications)

Parent/guardian/carer

Date	Time
	[] am [] pm

Director/educator/coordinator

Date	Time
	[] am [] pm

Other agency (if applicable)

Date	Time
	[] am [] pm

Regulatory authority (if applicable)

Date	Time
	[] am [] pm

Parental acknowledgement:

I,
(name of parent/guardian/carer)

have been notified of my child's [] incident [] injury [] trauma [] illness.
(Please select either incident/injury/trauma/illness)

Signature

Date

Sara Jensen

Additional notes:

--