

Educator first name: _____ Educator surname: _____

Date: _____ Time: _____ Signature: _____

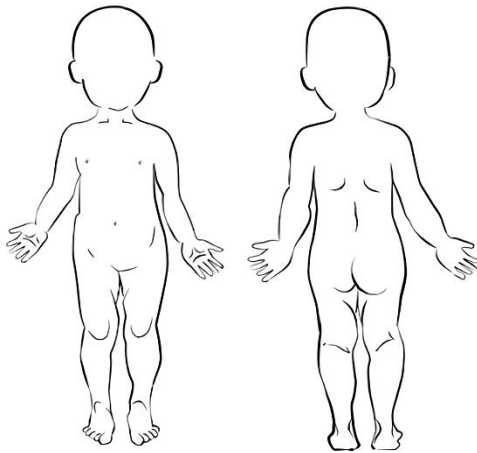
CHILD DETAILS

First name: _____ Surname: _____

Date of birth: _____ Age: _____ Sex: Male Female

NATURE OF INJURY, TRAUMA OR ILLNESS

Indicate on diagram the part of body affected, and select the relevant boxes.



- | | |
|---|--|
| <input type="checkbox"/> Abrasion / scrape | <input type="checkbox"/> Electric shock |
| <input type="checkbox"/> Allergic reaction (not anaphylaxis) | <input type="checkbox"/> Eye injury |
| <input type="checkbox"/> Amputation | <input type="checkbox"/> Infectious disease (including gastrointestinal) |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> High temperature |
| <input type="checkbox"/> Asthma / respiratory | <input type="checkbox"/> Ingestion / inhalation / insertion |
| <input type="checkbox"/> Bite wound | <input type="checkbox"/> Internal injury / infection |
| <input type="checkbox"/> Bruise | <input type="checkbox"/> Poisoning |
| <input type="checkbox"/> Broken bone / fracture / dislocation | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Burn / sunburn | <input type="checkbox"/> Respiratory |
| <input type="checkbox"/> Choking | <input type="checkbox"/> Seizure / convulsion / unconsciousness |
| <input type="checkbox"/> Concussion / unconsciousness | <input type="checkbox"/> Sprain / swelling |
| <input type="checkbox"/> Crush / jam | <input type="checkbox"/> Stabbing / piercing |
| <input type="checkbox"/> Cut / open wound | <input type="checkbox"/> Venomous bite or sting |
| <input type="checkbox"/> Dental injury | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Drowning (non-fatal) | _____ |

INCIDENT/INJURY/TRAUMA OR ILLNESS DETAILS

Incident date: _____ Time: _____ Location (e.g. Backyard): _____

First name of witness: _____ Surname of witness: _____

Signature of witness: _____ Date: _____

Address where Incident occurred: _____

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 the service or was **locked in/out** of the service (incl. who took the child, duration): _____

INJURY/TRAUMA OR ILLNESS DETAILS (apparent on child's arrival)

Was the injury/trauma or illness apparent upon child's arrival?: Yes No

Details of injury/trauma or illness apparent upon child's arrival: _____

ACTION TAKEN

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

Did emergency services attend?: Yes No

Time Emergency Services Contacted: _____ Time Emergency Services Arrived: _____

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

If yes to either of the above, please provide details: _____

Have any steps been taken to prevent or minimise this type of incident in the future? Provide details: _____

NOTIFICATIONS (including attempted notifications)

Parent / guardian: _____ Date: _____ Time: _____

Coordinator: _____ Date: _____ Time: _____

PARENTAL ACKNOWLEDGEMENT

Parent first name: _____ Parent surname: _____

I hereby declare that I have been notified of my child's incident, injury, trauma or illness.

Parent signature: _____ Date: _____

