

Incident, injury, trauma and illness record

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| **Details of person completing this record** |
| Name |  | Position/role |  |
| Date and time record was made |  | Signature |  |
| **Child Details** |
| Child’s full name |  |
| Date of Birth |  | Age |  | Gender |  |
| **Incident Details** |
| Incident Date |  | Time |  | Location |  |
| Name of witness |  |
| Witness signature |  | Date |  |
| General activity at the time of **incident/injury/trauma/illness** |  |
| **Last time the child:** |
| Ate: |  | AM/PM | Drank: |  | AM/PM |
| Details: |  | Details: |  |
| Cause of **injury/trauma** |
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| Circumstances surrounding any illness, including apparent symptoms |
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| Circumstances if child appeared to be missing or otherwise unaccounted for (incl. duration, who found child etc.): |
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| 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) |
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| **Nature of injury/trauma/illness** |
| **Indicate on diagram the part of body affected** |
| A picture containing linedrawing  Description automatically generated |[ ]  Abrasion/Scrape |[ ]  Eye Injury |
|  |[ ]  Allergic reaction (not anaphylaxis) |[ ]  Infectious disease (incgastrointestinal) |
|  |[ ]  Amputation |[ ]  High temperature |
|  |[ ]  Anaphylaxis |[ ]  Ingestion/inhalation/insertion |
|  |[ ]  Asthma/respiratory |[ ]  Internal injury/infection |
|  |[ ]  Bite wound |[ ]  Poisoning |
|  |[ ]  Bruise |[ ]  Rash |
|  |[ ]  Broken bone/fracture/dislocation |[ ]  Respiratory |
|  |[ ]  Burn/sunburn |[ ]  Seizure/unconscious/convulsion |
|  |[ ]  Choking |[ ]  Sprain/swelling |
|  |[ ]  Concussion |[ ]  Stabbing/piercing |
|  |[ ]  Crush/jam |[ ]  Tooth |
|  |[ ]  Cut/open wound |[ ]  Venomous bite/sting |
|  |[ ]  Drowning (non‐fatal) |[ ]  Other (please specify below) |
|  |[ ]  Electric shock |[ ]   |
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| **Action Taken** |
| Details of action taken (including first aid, administration of medication etc) |
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| Did emergency services attend? |  |
| Was medical attention sought from a registered practitioner / hospital? |  |
| If yes to either of the above, provide details |
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| Have any steps been taken to prevent or minimise this type of incident in the future? |
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| **Notifications (including attempted notifications)** |
|  | **Time** | **Date** |
| Parent/guardian |  |  |  |
| Responsible Person In Charge |  |  |  |
| Approved Provider (if applicable) |  |  |  |
| Regulatory authority (if applicable) |  |  |  |
| (Shine Bright EYM Central Office to Notify Central Office to Notify DET) |
| **Parental Acknowledgement** |
| I |  | (name of parent/guardian/authorized person) |
| have been notified of my child’s |  |
| Signature |  | Date |  |
| If parent does not collect child on the day, parent to sign below at their earliest opportunity. |
| Parent Name |  | Date |  |
| Signature |  |
| Parent Comments/Feedback |
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| **Additional notes and Actions** |
| Child’s Teacher to make a follow up phone call to child’s parents and any other parents involved within 24 hours to touch base and ask how they are and if they would like to raise this as a complaint. Teacher to record conversation here and sign and date |
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| Signed Teacher |  | Date |  |
| Name if unable to sign doc |  |