

## ACCIDENT, INCIDENT, INJURY, TRAUMA AND ILLNESS RECORD

To be completed as soon as possible, but no later than 24hrs after the accident, incident, injury or trauma, or the onset of the illness

### 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 : ☐ Male ☐ Female

### Incident details

Incident date: ...../...../..... Time: ..... am/pm Location: .....

Name of witness (who actually observed the incident): .....

Witness signature: ..... Date: ...../...../.....

General activity at the time of **accident/incident/injury/trauma/illness**:

.....

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.....

.....

Cause of **injury/trauma/ illness**: .....

.....

.....

.....

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): .....

.....

.....

.....

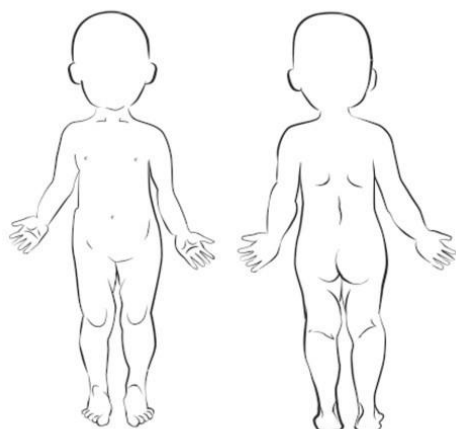
Circumstances if child appeared to have been **taken or removed** from service or was **locked in/out** of service (incl who took the child, duration): .....

.....

.....

**Nature of accident/incident, injury/trauma/illness:**

Indicate on diagram the part of body affected



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

**Action Taken**

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

.....

.....

.....

Did emergency services attend?: Yes / No

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?:.....

.....

.....

.....

## Notifications (including attempted notifications)

Parent/guardian: ..... Time: ..... am/pm Date: ...../...../.....

Director/educator/coordinator: ..... Time: ..... am/pm Date: ...../...../.....

Other agency (if applicable): ..... Time: ..... am/pm Date: ...../...../.....

Regulatory authority (if applicable): ..... Time: .....am/pm Date: ...../...../.....

**Parental acknowledgement:**

(name of parent/guardian)

have been notified of my child's accident/incident/injury/trauma/illness.

(Please circle)

Signature: ..... Date: ...../...../.....

**Additional notes:**

**OFFICE USE ONLY - Follow up:** to be completed with details of outcome

Copy forwarded to Coordination Unit: ☐ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Coordinator Signature: \_\_\_\_\_