CABONNE FAMILY DAY CARE
103 BANK STREET, MOLONG NSW 2866
SERVICE ABN: 41 992 919 200
PH: 02 6392 3219 | EMAIL: fdc@cabonne.nsw.gov.au

INCIDENT, INJURY, TRAUMA ILLNESS REPORT

Please circle type of record:

Incident ☑ Injury ☐ Trauma ☐ Illness ☐

CHILD DETAILS Gender: ☐ Male ☐ Female

Surname: _____ Given Name: _____

Date of Birth: _____ Age, including months: _____

DETAILS OF INCIDENT, INJURY, TRAUMA, OR ILLNESS

Date of Incident: _____ Time: _____ Location: _____

Please provide a descriptive outline of what happened:

Circumstances leading up to the incident:

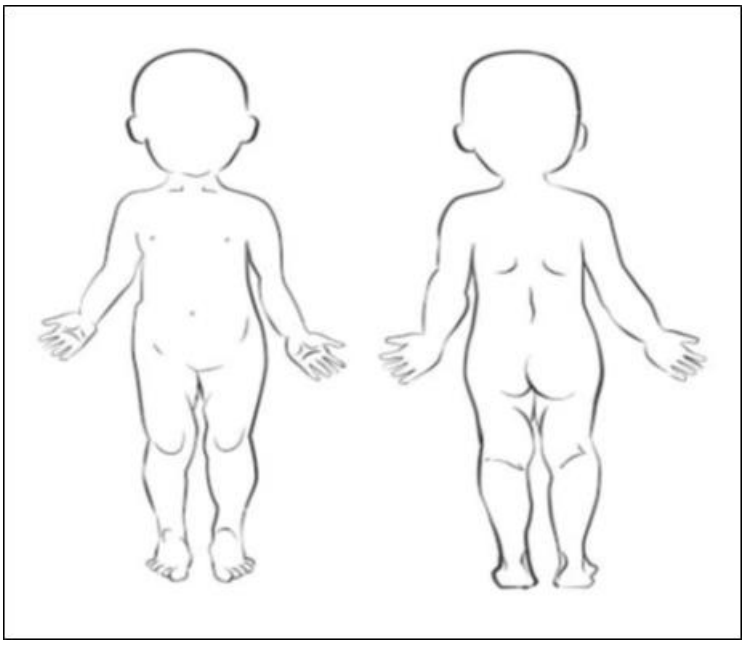
Products, structures, foods etc. involved:

FOR INJURY AND/OR TRAUMA

Nature of injury sustained (please tick)

O Abrasion/Scrape
O Allergic Reaction
O Amputation
O Anaphylaxis
O Asthma
O Bite wound
O Bruise
O Broken bone/fracture/dislocation
O Burn/Sunburn
O Choking
O Concussion
O Crush/Jam
O Cut/Open Wound
O Drowning (non-fatal)
O Electric Shock
O Eye injury
O Infectious Disease
O High Temperature
O Ingestion/inhalation/insertion
O Internal injury/infection
O Poisoning
O Rash
O Respiratory
O Seizure/Unconscious/Convulsion
O Sprain/Swelling
O Stabbing/Piercing
O Tooth
O Venomous Bite/Sting
O Other (please specify) _____

Please indicate area of body affected on diagram below:



☐ **This page is not applicable to this report**

FOR ILLNESS

The child has been displaying the following symptoms:

- ☐ Server, persistent or prolonged coughing
- ☐ Difficult or rapid breathing
- ☐ Eye discharge
- ☐ Nose discharge
- ☐ Unusual spots or rash
- ☐ Headache or stiff neck
- ☐ Irritable when disturbed
- ☐ Difficult to wake
- ☐ Felt cold and looked pale
- ☐ Diarrhoea
- ☐ Frequent scratching of scalp or skin
- ☐ Lost interest in playing
- ☐ Abnormally quiet and inactive
- ☐ Crying readily and could not be comforted
- ☐ Feverish appearance
- ☐ Vomiting
- ☐ Symptoms of possible infectious disease

If the child had a high temperature, please record it every 10 minutes:

1. Time: _____ Temp: _____
2. Time: _____ Temp: _____
3. Time: _____ Temp: _____
4. Time: _____ Temp: _____
5. Time: _____ Temp: _____
6. Time: _____ Temp: _____

☐ **The above section is not applicable to this report**

ACTION TAKEN – Please complete all questions

1. Outline action taken, including first aid and administration of medications:

2. Did emergency services attend? ☐ Yes ☐ No
3. Did child go to registered practitioner? ☐ Yes ☐ No
4. Did child go to the hospital? ☐ Yes ☐ No
5. If the child did not seek medical advice, why was this the case and was this decision made by the parent or educator?

6. If the child left your service to received medical attention, did they return to care after receiving the medical attention? ☐ Yes ☐ No ☐ N/A
7. Did the child attend the next booked session of care, or are they expected to attend the next booked session? ☐ Yes ☐ No ☐ N/A
8. What steps will you take to prevent, or minimise, this type of incident in the future?

NOTIFICATION (including attempted notifications)

Parent/Guardian: _____ Time: _____ am/pm Date: _____

Principle Office: _____ Time: _____ am/pm Date: _____

Other: _____ Time: _____ am/pm Date: _____

DETAILS OF PERSON COMPLETING RECORD

Name: _____ Signature: _____

Time record was made: _____ am/pm Date: _____

WITNESS DETAILS

Name: _____

Signature: _____ Date: _____

Contact number: _____

Email Address: _____

PARENTAL ACKNOWLEDGEMENT

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

Signature: _____ Time: _____ am/pm Date:_____

Please indicate:

☐ I want a copy of this incident report emailed to me

☐ I **do not** want a copy of this incident report

ADDITIONAL NOTES & FOLLOW UP

PRINCIPLE OFFICE

Name: _____

Signature: _____ Date: _____

Date incident report received: _____

Date incident report submitted to regularly authority (if required): _____