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: _____

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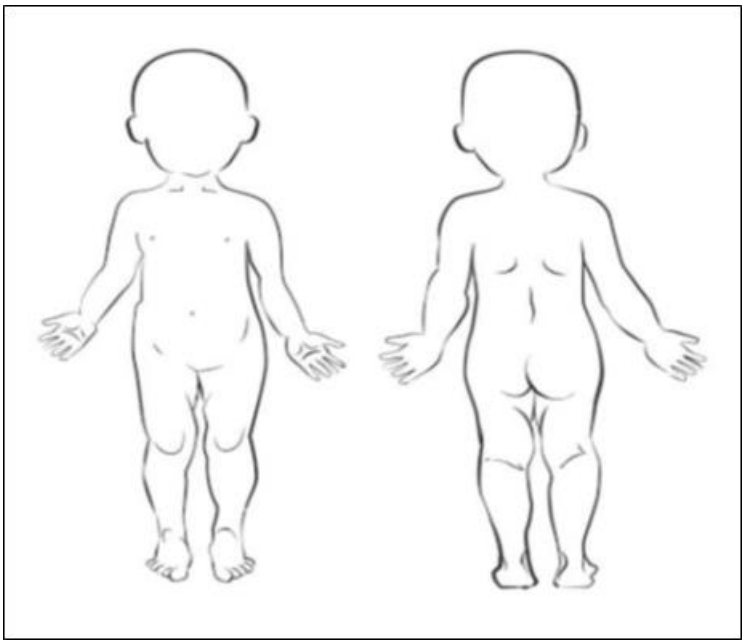
FOR INJURY AND/OR TRAUMA

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 submitted to regularly authority (if required): _____