

INCIDENT REPORT (Educator to Complete

2018,

The appropriate areas on this form **must** be completed following any incident where a child sustains an injury. If the child requires any form of professional medical assistance, or suffers from a fit, convulsion or suspected concussion, a <u>Public Liability Insurance</u> Incident Report Form must be immediately completed and submitted in addition to this form. The documents must be received within 24 hours of the incident occurring.

Child's Full name		
Child's DOB:		
Date of Incident:	Time	
Location incident occurred	(Describe in full including the products or structures involved)	
_	e incident/trauma/injury/ illness:	
(Describe what happened in full what happened a	and who was involved, for illness detail symptoms and action)	
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Injury sustained: (describe the s	ize, colour, depth, etc. of the marks left on the child's body	Indicate location of Iniurv
A citizen (all and (day a day and ari		
Action taken / treatment giv	Ven by Educator: nedication. If medication is administered attach the form	
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Name of authorised		Date		Time		
person/parent contact	ed	Date		Time		
about the incident.		Date		Time		
Details of parent				·		
notification if applicab	le:					
Name of witnesses oth	ier		Signature			
than the educator:						
			/5			
Medical assistance sought? Yes/No by the Educator / Parent						
Reason why medical assistance was or was not sought by the educator:						
If medical assistance was sought please list details of clinic and doctor						
Clinic:						
Details of medical treatment: (Describe in full – Please use back of page if)						
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	_					
Details of any further f	ollow up action required or	undertaken	:			
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Educator Name:						
Address:						
Phone:		Mobile:				
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Name of person		Parent/Guar	dian:			
completing the record:						
			Signature:			
Signature:		Signature:				
Signature:		Signature:				
Date and Time the		Signature: Date:				
Date and Time the record was make OFFICE USE:						
Date and Time the record was make						