

Injury/Incident/Trauma Record



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Details of person completing this record – Name:..... Position/Role:.....

Date & Time Record was made:..... Signature:.....

Name of Child/Staff: D.O.B: Age: Gender:.....

Injury/incident/trauma date: Time: Location:

Circumstances leading to the injury/incident /trauma (general activity):

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Cause of injury/incident/trauma:.....

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.....

Nature of injury/trauma:.....

.....

.....

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

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.....

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:.....

.....

Parent/Person contacted:Time:Date:.....

Parent/Guardian Name: Contact phone number:

Contact Email Address:

Follow up phone call yes/no:

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Number of Children at time of injury/incident/trauma: Number of Staff:

Location of Staff (attach supervision plan if incident occurred outside/draw map of room if incident occurred inside):

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Additional notes / follow up:

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Approved Provider/Management Notified (If applicable):Date:.....Time:.....

Regulatory Authority Notified via NQAITS (If applicable): Yes / No Date:..... Time:.....

Other Agency Notified (if applicable):.....Date:..... Time:.....

Parent Acknowledgement

I have been notified of my child’s injury/incident/trauma (please circle)

Parent/Guardian signature: Date:

Supervisor signature: Date:

Staff witness name: Date:

Staff witness signature: Date: