

Accident / Incident Form



Child's name _____

Child's date of birth DD/MM/YY

Parent/guardian contacted prior to collection (Yes and how, no and why) _____

Date DD/MM/YY Time of accident 24:00

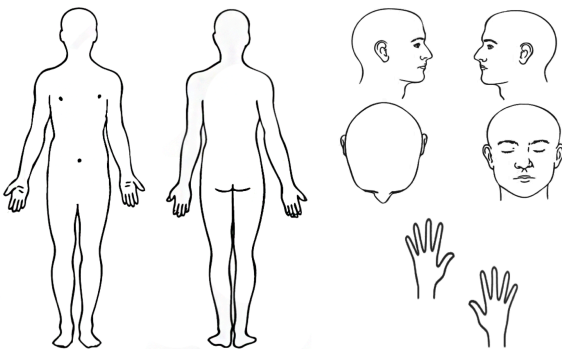
Head Injury Report completed YES NO Head Monitoring completed YES NO

Where did the accident happen: _____

Description of accident: _____

Injury sustained: _____

Treatment given: _____



Name of staff who dealt with accident: _____

Name of staff who saw accident: _____

Name of adults present on the day: _____

Further action required or additional details (example: medical attention required): _____

Name of staff who filled out the form: _____ Signature: _____

Manager/Deputy Manager signature: _____ Date: _____

Parent/Carer's signature: _____ Date: _____

Additional comments: _____

