MARIBYRNONG PRIMARY SCHOOL

Alberga Street
KALEEN ACT 2617
Telephone: 02 62055933
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INCIDENT / INJURY / TRAUMA RECORD

This record should be completed as soon as practicable, but no later than 12 hours after the incident, injury or trauma.

NAME OF CHILD: _____ DOB: ____ / ____ / ____

EVENT: ☐ INJURY ☐ INCIDENT ☐ TRAUMA (please tick)

DATE OF EVENT: _____ / _____ / _____ TIME OF EVENT: _____ am/pm

CIRCUMSTANCES SURROUNDING THE EVENT:

ACTION TAKEN BY STAFF (INCLUDING FIRST AID, MEDICAL PERSONNEL NOTIFIED):

WITNESS DETAILS:

1	Name:	Ph:
2	Name:	Ph:
3	Name:	Ph:

PERSONS NOTIFIED OR ATTEMPTED TO BE NOTIFIED:

1	Name: Ph:	Date: _____ / _____ / _____ Time: _____ am/pm
2	Name: Ph:	Date: _____ / _____ / _____ Time: _____ am/pm
3	Name: Ph:	Date: _____ / _____ / _____ Time: _____ am/pm

FORM COMPLETED BY:

Name:	Signature:
Date:	Time: