

Incident Report Form

[Please answer all questions to best of knowledge]

Name of Playgroup: _____ Affn No: _____

Name of Co-ordinator, email address & tel no: _____

Date reported to coordinator: _____ Time reported: _____

Playgroup venue (if different from location of incident): _____

Date of incident: _____ Time of incident: _____ Day of week: _____

Name of person making report: _____ Incident reported to: _____

Time incident location inspected: _____ Inspected by: _____

Part 1: Injured person details

Name of injured: _____ (Surname) _____ (Given Names)

Address: _____

Telephone no: (Mobile) _____ (Home) _____ (Business) _____

Date of Birth: _____ (approx.) Gender: Male Female

Does child have: Glasses Other impairments

Please give details of impairments: _____

Part 2: Witness * details

* Eyewitnesses witnessed the incident; circumstantial witnesses witnessed the events leading up to or following the incident. Additional witnesses' details should be provided on separate attachment.

Attach statements for additional comments.

Name of witness or parent/ carer to accident/ incident:

(Surname) (Given names)

Membership No: _____ Receipt No: _____ Date joined: _____

Address of witness: _____

Telephone no: (Mobile) _____ (Home) _____ (Business) _____

Type of witness : Eye witness Circumstantial witness

Relationship to injured person: _____

If another party responsible please provide details: _____



Part 3: Personal injury details

Part of body injured (Place tick appropriate box)

- | | | | | | |
|--------------|--------------------------|--------------|--------------------------|----------------|--------------------------|
| Head & neck | <input type="checkbox"/> | Hip | <input type="checkbox"/> | Hands/ Fingers | <input type="checkbox"/> |
| Eyes or Face | <input type="checkbox"/> | Shoulder | <input type="checkbox"/> | Knee | <input type="checkbox"/> |
| Back & trunk | <input type="checkbox"/> | Arms/ Wrists | <input type="checkbox"/> | Feet & Toes | <input type="checkbox"/> |

If Other, or multiple, please describe:

Nature of injury (Place tick appropriate box)

- | | | | | | |
|-----------------|--------------------------|-------------------------------------|--------------------------|--|--------------------------|
| Multiple | <input type="checkbox"/> | Minor bruise- Not disabling | <input type="checkbox"/> | Concussion/ Unconscious (Serious) | <input type="checkbox"/> |
| Fracture | <input type="checkbox"/> | Major bruising- Disabling | <input type="checkbox"/> | Burns/ Scalds- requiring medical attention | <input type="checkbox"/> |
| Sprain | <input type="checkbox"/> | Minor Cut/ Laceration- No stitches | <input type="checkbox"/> | Superficial | <input type="checkbox"/> |
| Dislocation | <input type="checkbox"/> | Cut/ Laceration- requiring stitches | <input type="checkbox"/> | No Apparent injury | <input type="checkbox"/> |
| Ligament Damage | <input type="checkbox"/> | Minor Concussion | <input type="checkbox"/> | | |

If Other, please describe:

Description of incident (by you or independent witness). Please give a complete summary of the incident:

Was injured person taken to: Treatment by First Aider: Doctor/ Hospital: Ambulance:

Name of First Aider/ person attending: _____ Contact No: _____

Other (Please describe): _____

If third party/ contractor at fault: Third party/ contractor's name:

Part 4: Property Damage

(Complete if there is property damage)

Item damaged:

Details:

If viewed and by whom:

Photos taken and by whom:



Part 5: Location of incident

(Please tick in appropriate box)

Car Park Ramps	<input type="checkbox"/>	Common Areas- Others	<input type="checkbox"/>	Stairs	<input type="checkbox"/>
Entrance/ Exit	<input type="checkbox"/>	Office Areas	<input type="checkbox"/>	Moving Walkways	<input type="checkbox"/>
Escalators	<input type="checkbox"/>	Internal Ramp	<input type="checkbox"/>	Elevators	<input type="checkbox"/>
Toilet Areas	<input type="checkbox"/>	Children's Play Area	<input type="checkbox"/>	Restaurants	<input type="checkbox"/>
Common Areas- Kitchen	<input type="checkbox"/>	Car Parks	<input type="checkbox"/>	Others	<input type="checkbox"/>

If Other, please describe:

Part 6: Type of Incident

(Please tick in appropriate box)

If slip and Fall of Person:

Lack of Barrier	<input type="checkbox"/>	Uneven floor	<input type="checkbox"/>	Kids running	<input type="checkbox"/>
Rainwater on floor	<input type="checkbox"/>	Tripped over Object	<input type="checkbox"/>	Steps/ Stairs	<input type="checkbox"/>
Floor Slippery (Surface)	<input type="checkbox"/>	Vegetable/ Fruit items on floor	<input type="checkbox"/>	Car Park Stops/ Bollards	<input type="checkbox"/>
Inadequate lighting	<input type="checkbox"/>	Person running	<input type="checkbox"/>	No apparent reason	<input type="checkbox"/>

If Other, please describe:

Type of floor surface where incident happened:

Marble	<input type="checkbox"/>	Timber	<input type="checkbox"/>	Concrete	<input type="checkbox"/>
Terrazzo	<input type="checkbox"/>	Vinyl	<input type="checkbox"/>	Speed hump	<input type="checkbox"/>
Slate	<input type="checkbox"/>	Carpet	<input type="checkbox"/>	Dirt/ Grass/ Garden	<input type="checkbox"/>
Tile	<input type="checkbox"/>	Bitumen	<input type="checkbox"/>	Other	<input type="checkbox"/>

If Other, please describe:

Caught in:

Door	<input type="checkbox"/>	Escalator/ Elevator	<input type="checkbox"/>
Machinery	<input type="checkbox"/>	Other	<input type="checkbox"/>

If Other, please describe:

Stepping on or Striking Against:

Display Stands	<input type="checkbox"/>	Escalator/ Elevator	<input type="checkbox"/>	Doors	<input type="checkbox"/>
Sharp Edges	<input type="checkbox"/>	Protruding Objects	<input type="checkbox"/>	Other	<input type="checkbox"/>

If Other, please describe:



Other:

Falling Objects

If Falling Objects, please describe:

Signature of person making this Incident Report

Date

Name

Note:

It is important that you keep accurate records of injuries or accidents at Playgroup involving children, adults and/or visitors

- Record incidents immediately while information is fresh
- Forward incident report to Finsura Insurance Broking with copy to Playgroup WA

Send to : Finsura Insurance Broking (Aust) Pty Ltd
PO Box 686, Castle Hill, NSW 1765
Or email to playgroup@finsura.com.au
Tel : 1800 252 712 or 02 9899 2999