SCHOOL LOGO HERE

School Name
1 Teaching Lane, Schoolsville, EDU C8

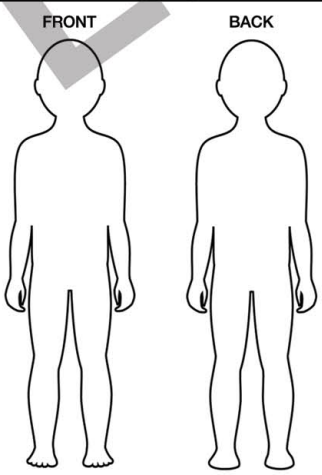
t. 00000 000000
e. info@yourwebaddress.co.uk
www.yourwebaddress.co.uk

Report No.
0001

ACCIDENT, INCIDENT, ILLNESS REPORT SLIP

Date: / /	Time: :	Child's Class:	
Child's Name:			
Incident location in School:			
Incident Details:			

☐ Bump / Bruise	☐ Following First Aid the Child was well enough to remain in School
☐ Vomiting / Nausea	☐ The Child was collected from School
☐ Nosebleed	☐ Parent advised that they may wish to consult a Doctor
☐ Headache / Feeling Hot	
☐ Head Injury	
☐ Cut / Graze	
☐ Asthma	
☐ EPI Pen	
☐ Parent Contacted	
☐ Unable to contact Parent	



Treatment Administered:	

First Aider:	Parent/Carer Contacted:
Witness:	Collected by:
Slip completed by:	Signature:

IMPORTANT: *Should your child suffer any drowsiness, vomiting, impaired vision or excessive pain after returning home please consult your Doctor or local Hospital.*