



Illness, Injury & Indicators of Abuse Log



**Maintain
On-Site**

- You can use this form or you can create your own master form using this as a guide.
- It is required that a daily health check be conducted and recorded for each child.
- Symptoms of illness include but are not limited to: wheezing, coughing, runny nose, change in appetite, crying, pulling of ears, wetting of clothes, etc.
- Suspicions of child abuse/neglect may include but are not limited to: unexplained bruises, injuries; burns; swelling, itching, bleeding, cuts in genital or anal areas, lack of medical care/attention, malnutrition, etc.

As a child care provider you are required to report serious incidents and injuries to the OCFS Regional Office or your Registrar.

As a mandated reporter of child abuse and maltreatment, you are required to report suspected child abuse to the child abuse hotline at 1-800-635-1522.

PROVIDER/FACILITY NAME:		CHILD'S NAME:	
FACILITY ID NUMBER:	FACILITY TELEPHONE NUMBER:	CHILD'S DATE OF BIRTH: / /	

OBSERVATION/ASSESSMENT

DATE	TIME	SYMPTOMS OF ILLNESS/ DESCRIPTION OF INJURY	OR	SUSPICIONS OF ABUSE/ NEGLECT	ACTIONS TAKEN	CHILD DISMISSED	NAME AND INITIALS OF PERSON REPORTING ILLNESS/INJURY/ABUSE
/ /	: <input type="checkbox"/> AM <input type="checkbox"/> PM					<input type="checkbox"/> YES <input type="checkbox"/> NO	PRINT YOUR NAME INITIAL HERE
/ /	: <input type="checkbox"/> AM <input type="checkbox"/> PM					<input type="checkbox"/> YES <input type="checkbox"/> NO	PRINT YOUR NAME INITIAL HERE
/ /	: <input type="checkbox"/> AM <input type="checkbox"/> PM					<input type="checkbox"/> YES <input type="checkbox"/> NO	PRINT YOUR NAME INITIAL HERE
/ /	: <input type="checkbox"/> AM <input type="checkbox"/> PM					<input type="checkbox"/> YES <input type="checkbox"/> NO	PRINT YOUR NAME INITIAL HERE
/ /	: <input type="checkbox"/> AM <input type="checkbox"/> PM					<input type="checkbox"/> YES <input type="checkbox"/> NO	PRINT YOUR NAME INITIAL HERE
/ /	: <input type="checkbox"/> AM <input type="checkbox"/> PM					<input type="checkbox"/> YES <input type="checkbox"/> NO	PRINT YOUR NAME INITIAL HERE

(Continued on reverse side)

