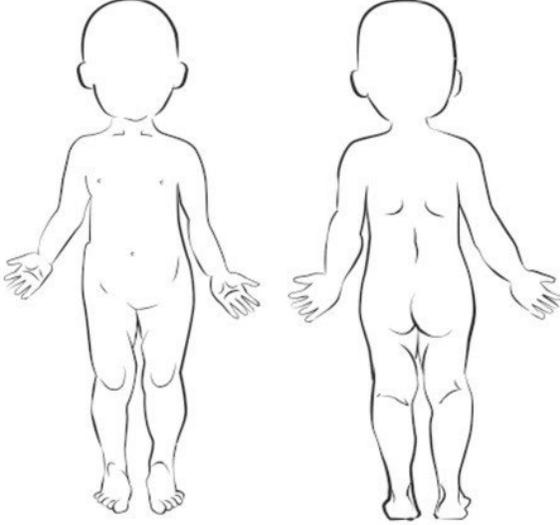


NATURE OF INJURY/TRAUMA SUSTAINED - (indicate part of body affected)			
	<input type="checkbox"/> Abrasions/ Scrape <input type="checkbox"/> Bite <input type="checkbox"/> Bruise <input type="checkbox"/> Burn/sunburn <input type="checkbox"/> Cut <input type="checkbox"/> Eye injury <input type="checkbox"/> Infectious disease <input type="checkbox"/> Rash <input type="checkbox"/> Sprain <input type="checkbox"/> Swelling <input type="checkbox"/> Tooth	<input type="checkbox"/> Lethargic/sleepy <input type="checkbox"/> Flushed Cheeks <input type="checkbox"/> Other (please specify) <hr style="border: 0; border-top: 1px solid #00aaff; margin: 2px 0;"/> <hr style="border: 0; border-top: 1px solid #00aaff; margin: 2px 0;"/> <hr style="border: 0; border-top: 1px solid #00aaff; margin: 2px 0;"/> <hr style="border: 0; border-top: 1px solid #00aaff; margin: 2px 0;"/> <hr style="border: 0; border-top: 1px solid #00aaff; margin: 2px 0;"/> <hr style="border: 0; border-top: 1px solid #00aaff; margin: 2px 0;"/>	
PARENT/GUARDIAN ACKNOWLEDGEMENT AND COMMENTS			
Parent/Guardian name			
Parent/Guardian signature			
Date		Time	
Additional notes/comments			

MONITORING/FOLLOW-UP REQUESTS