BERKS COUNTY CHILDREN & YOUTH SERVICES
INJURY REPORT

Child:_____ Date of Incident:_____

Foster Parent: _____ Time:_____a.m._____p.m.

Description of Injury:

What happened?

What was done by the foster parent?

Was medical treatment necessary? Yes ____ No ____

If yes, indicate the treating physician, hospital, clinic, and the discharge recommendation (including any prescribed medication)

When was the Agency notified? _____

How? (phone, Emergency Duty, email) _____

Signatures:

BCCYS Foster Parent

_____

Resource Family Supervisor

Revised 08/11

CC: GAL notification date _____