



YOLO COUNTY UNUSUAL INCIDENT REPORT

Resource Family Name:	
Address:	
Contact Phone number:	

Date of Incident: _____ **Time of Incident:** _____ A.M. /P.M.

LOCATION OF INCIDENT:	<input type="checkbox"/> Foster Home	<input type="checkbox"/> School	<input type="checkbox"/> Agency
	<input type="checkbox"/> Other: _____		

Reported to the following

Name Reported too:
Date Reported:
Assigned Yolo County Social Worker:
<i>Yolo County Mental Health Staff:</i>
RFA Social Worker:

Foster Child(ren) Involved:

Name:	DOB:	Name:	DOB:
Name:	DOB:	Name:	DOB:

Other Persons Involved: (Indicate whether other persons involved are members of the foster home)

Name:	Relationship:
Name:	Relationship:
Name:	Relationship:

Type of Incident (Check all that apply):

<input type="checkbox"/> Accidental Injury	<input type="checkbox"/> Youth Threatened Suicide	<input type="checkbox"/> Self-Inflicted Injury
<input type="checkbox"/> Unknown Injury	<input type="checkbox"/> Youth Attempted Suicide	<input type="checkbox"/> AWOL
<input type="checkbox"/> Youth Threatened Suicide	<input type="checkbox"/> Youth Committed Suicide	<input type="checkbox"/> Use of Restraint (No Injury)
<input type="checkbox"/> Youth Injured During Incident	<input type="checkbox"/> Youth Became Violent	<input type="checkbox"/> Youth Fighting

Youth Threatened Other(s)	Name(s): _____
Youth Injured Other(s)	Name(s): _____
Property Damage/Loss	Specify: _____
Youth Committed Criminal Act	Specify: _____
Unintentional Drug/Substance Overdose	Specify drug/substance: _____
Intentional Drug/Substance Overdose	Specify drug/substance: _____
Suspicious/Unusual Cause of Death Other	Specify: _____

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Type of Injury (Check all that apply):

<input type="checkbox"/> None	<input type="checkbox"/> Bruise	<input type="checkbox"/> Swelling	<input type="checkbox"/> Possible Fracture/ Dislocation	<input type="checkbox"/> Other: <i>Specify</i> _____
<input type="checkbox"/> Bite	<input type="checkbox"/> Burn	<input type="checkbox"/> Sprain	<input type="checkbox"/> Fracture/ Break	

Description of Incident/Cause of Injury:

Action(S) Taken (Check all that apply):

<input type="checkbox"/> Youth Taken to Hospital by Foster Parent/Caretaker	<input type="checkbox"/> Youth Treated by Family Doctor Emergency Counseling Appointment
<input type="checkbox"/> Youth Treated by Paramedics	<input type="checkbox"/> Youth Treated in Emergency Room
<input type="checkbox"/> Youth Treated by Foster Parent	<input type="checkbox"/> Youth Treated by Other; specify _____
<input type="checkbox"/> Youth Admitted to Hospital Youth Admitted to Psychiatric Unit	<input type="checkbox"/> Youth Arrested Youth Placed in Juvenile Detention
<input type="checkbox"/> None	

Results of Action Taken:

Further Action(S) Required? NO YES (explain):

Form Completed By: _____

Relationship to Child: _____

* Form needs to be completed within 24 hours and sent to: Alicia.Wasklewicz@volocounty.org