Lancaster Community School District

Students

CHILD ABUSE REPORT

This form must be completed within 24 hours of verbal report to department of social services. After completing, this form must be given to the Grant County Social Service department, to the building principal, and school nurse and/or contact person and kept in confidential file.

TO: Grant County Department of Social Services
P.O. Box 111
Lancaster, WI 53813

FROM:

SCHOOL:

CHILD'S NAME _____ DATE OF BIRTH _____

ADDRESS _____ SCHOOL _____

ALLEGED PERPETRATOR'S NAME _____

ADDRESS

(WORK) _____ (PHONE) _____

(HOME) _____ (PHONE) _____

RELATIONSHIP TO CHILD _____ AGE _____

PERSON(S) RESPONSIBLE FOR CHILD: _____

FATHER ADDRESS _____

HOME PHONE _____ WORK PHONE _____

MOTHER ADDRESS _____

HOME PHONE _____ WORK PHONE _____

EMERGENCY PHONE NUMBER _____

OTHER ADULTS IN HOME _____

RELATIONSHIP _____

OTHER CHILDREN IN HOME:

NAME DATE OF BIRTH SCHOOL

_____
_____
_____
_____

CIRCUMSTANCES LEADING TO THE SUSPICION THAT THE CHILD IS A VICTIM OF ABUSE, INCLUDING THE NATURE OF THE INJURY, IF ANY:

_____
_____
_____
_____

NATURE AND EXTENT OF SUSPECTED ABUSE OR NEGLECT (Include time of occurrence, injury, people present during alleged incident, medical treatment provided, police involvement):

_____
_____
_____
_____

OTHER PERTINENT INFORMATION **(**i.e. parent/guardian contact and response):

_____
_____
_____
_____

REPORT MADE BY _____ DATE MAILED _____

VERBAL REPORT TO: Dept. of Social Services

DATE _____ TIME _____

COPY TO CONTACT PERSON _____ DATE _____

COPY TO SCHOOL NURSE _____ DATE _____

EXHIBIT APPROVED: April 13, 2005