SPECIAL INCIDENT REPORT

Facility Name: **David & Margaret Foster Family Agency** License #: **191592787**
Address: **1350 Third Street, La Verne, CA 91750** Telephone: **(909) 593-0089**

Foster Home:

Family Name:

Address/Phone:

Client(s) Involved:

Name	Sex	Date of Birth	Date Placed	County

Incident:

Date	Time	Location (include address and phone number)

Adult(s) present during incident:

Type of incident (check as many as apply)

	AWOL		Suicide Attempt		Alleged Child Abuse		Staff Related Incident
	Substance Abuse		School Incident		Injury/Illness		Sexually Related Incident
	Physical Violence		Police Involvement		Doctor/Dentist Visit		Other:

Describe the incident (Include what happened, to whom, where, how and method of intervention):

Signature of person making this report: ______________________

Print Name	Date and Time

PLEASE PLACE STAMP AND SIGNATURE HERE
(Please include doctor's name, address and phone number)

FOR STAFF USE ONLY

Conclusion (Assessment of what happened and why):

Signature of Staff Social Worker ______________________________

Print Name	*Date and Time*

*   *   *   *   *

Supervisor's Remarks (including administrative follow-up):

Supervisor's Signature ______________________________________

Print Name	*Date and Time*

*   *   *   *   *

Distribution:

	Name of Person Contacted	*Telephoned (Date)*	*Written/Fax (Date)*
Parent(s)/Guardian			
County Worker			
Licensing			
Monitor			
Child Abuse Report			
Police Department Report No.			
Other:			