



UNITED INDEPENDENT SCHOOL DISTRICT
SCHOOL HEALTH PROGRAM

SUSPECTED CHILD ABUSE REPORTING FORM

School _____ Phone No. _____

Name of Student _____ D.O.B. _____

Address _____ Phone No. _____

Name of parent or legal guardian _____ Relationship _____

Oral report made to _____ Date _____

(Name of Intake Worker)

(Telephone report must be made within 24 hrs)

Check appropriate box(es):

Nature of suspected abuse: Physical Sexual Emotional Neglect

Pertinent History: _____

Findings on physical assessment: _____

(Use separate sheets *if necessary*)

Principal's Signature

Signature of R.N./Counselor/Other

Title

Additional Notes:

