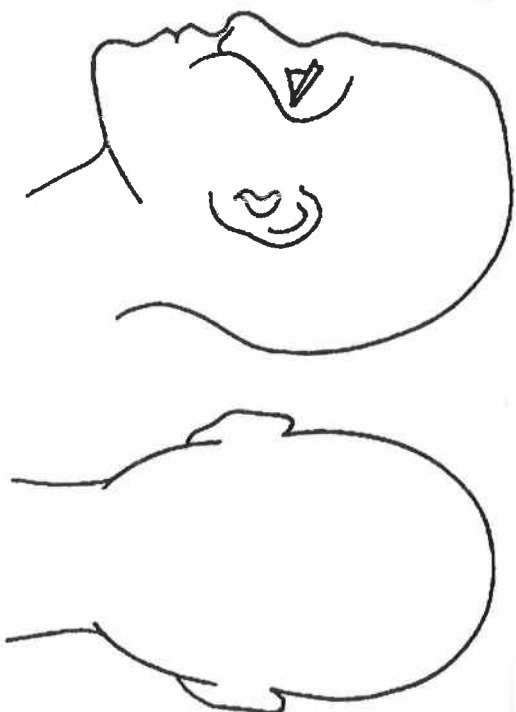
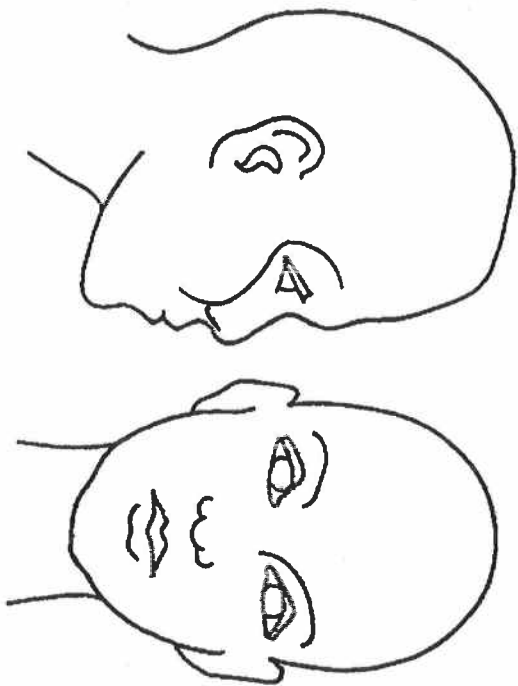
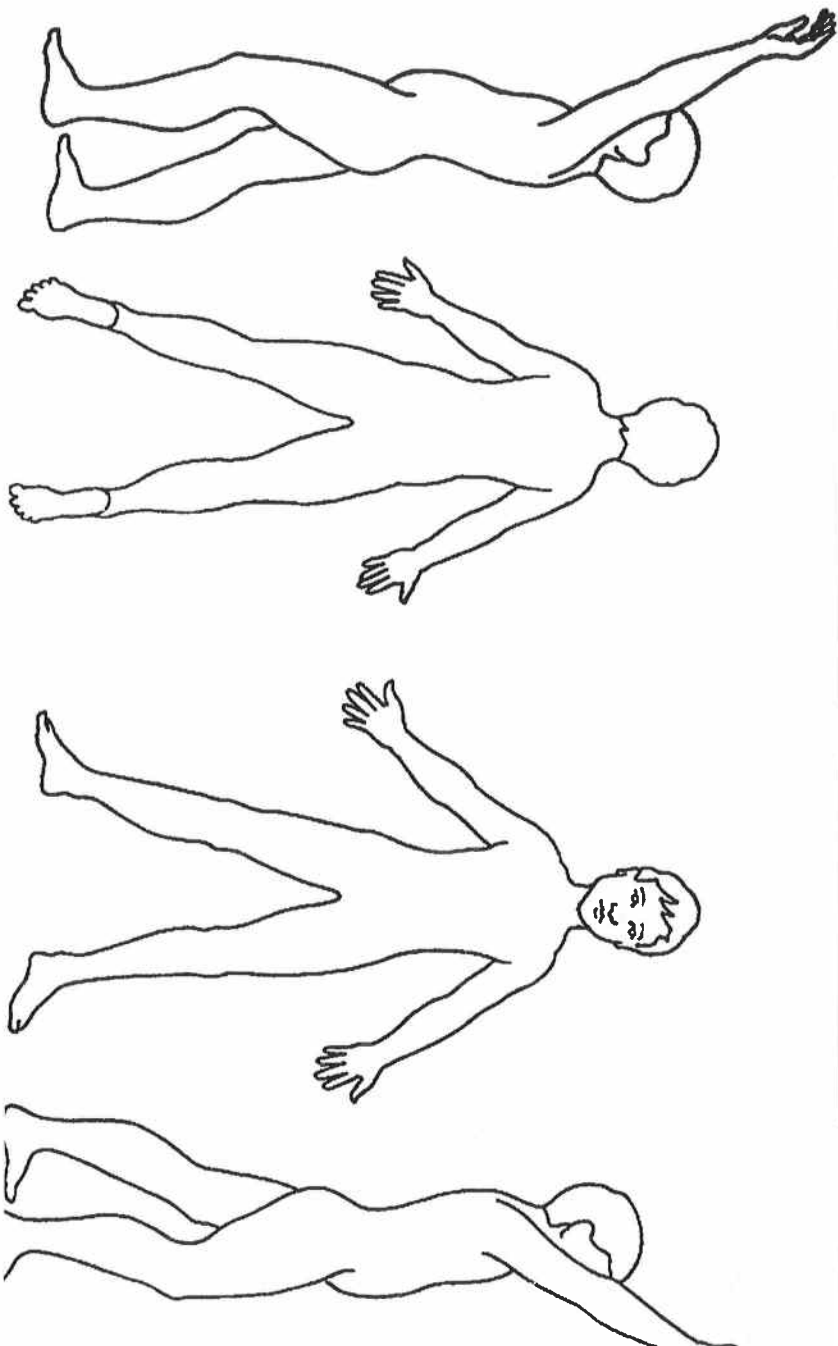


# BODY MAP

Please indicate the exact site of injury on map



Name of child: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Description of injury - size, shape, colour and type of injury: \_\_\_\_\_

\_\_\_\_\_

Date marks/injury observed: \_\_\_\_\_

Name of person completing this form: \_\_\_\_\_

Date: \_\_\_\_\_

Action: \_\_\_\_\_