

FORM 22
REPORTING OF ABUSE OR DELIBERATE NEGLECT OF CHILD
 (Regulation 33)
 [SECTION 110 OF THE CHILDREN'S ACT 38 OF 2005]

**REPORTING OF ABUSE TO PROVINCIAL DEPARTMENT OF SOCIAL DEVELOPMENT,
 DESIGNATED CHILD PROTECTION ORGANISATION OR POLICE OFFICIAL**

NOTE: A SEPARATE FORM MUST BE COMPLETED FOR EACH CHILD

TO: 1. The Head of the Department, Dept of Social Development

**2. The District Director, Dept of Education: For Attention CES: SDSS / Social Worker
 Copy for your attention and Register for Child Abuse Cases**

Pursuant to section 110 of the Children's Act, 2005, and for purposes of section 114(1)(a) of the Act, you are hereby advised that a child has been abused in a manner causing physical injury/ sexually abused/ deliberately neglected or is in need of care and protection.

Source of report (do not identify person)			
<input type="checkbox"/> Victim	<input type="checkbox"/> Relative	<input type="checkbox"/> Parent	<input type="checkbox"/> Neighbour/friend
<input type="checkbox"/> Professional (specify)			
<input type="checkbox"/> Other (specify)			
Date Reported to child protection organisation:	DD	MM	CCYY

1. CHILD: (COMPLETE PER CHILD)							
Surname				Full name(s)			
Gender:	M	F	Date of Birth:	DD	MM	CCYY	
School Name:			Grade:		Age / Estimated Age:		
* ID no:				* Passport no:			
Contact no:							

2. CATEGORY OF CHILD IN NEED OF CARE AND PROTECTION		
<input type="checkbox"/> Street child	<input type="checkbox"/> Child labour	<input type="checkbox"/> Child trafficking
<input type="checkbox"/> Commercial sexual exploitation	<input type="checkbox"/> Exploited children	<input type="checkbox"/> Child abduction

3. OTHER INTERVENTION – CONTACT PERSON TRUSTED BY CHILD	
Surname:	Name:
Address:	Telephone number:
Other children interviewed: <input type="checkbox"/> Yes <input type="checkbox"/> No Number :	

(*) = Complete if available or applicable

SURNAME OF CHILD:	
FULL NAMES OF CHILD:	

4. ALLEGED ABUSER						
4.1) Surname				Full Name(s)		
Date of Birth:	DD	MM	CCYY	Gender:	M	F
ID No:				Age:		
* Passport No:				* Drivers license:		
Also known as:				Relationship to child:		
Street Address (include postal code):				<input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Grand father <input type="checkbox"/> Grand mother <input type="checkbox"/> Step father <input type="checkbox"/> Step mother <input type="checkbox"/> Foster father <input type="checkbox"/> Foster mother <input type="checkbox"/> Uncle <input type="checkbox"/> Aunt <input type="checkbox"/> Sibling <input type="checkbox"/> Caregiver <input type="checkbox"/> Professional: social worker/police officer/teacher/caregiver/priest/dr/volunteer <input type="checkbox"/> Other (specify)		
				Postal Code:		
4.2) WHEREABOUTS OF ALLEGED PERPETRATOR:						
<input type="checkbox"/> Section 153 (Request for removal by SAPS) <input type="checkbox"/> Still in home <input type="checkbox"/> In hospital (Name/Place.....) <input type="checkbox"/> In detention (Place.....) <input type="checkbox"/> Living somewhere else <input type="checkbox"/> Whereabouts unknown <input type="checkbox"/> Un-identified						

5. PARENTS OF CHILD (If other than above)						
Surname: Father / Step-father				Full name(s)		
Date of Birth:	DD	MM	CCYY	Gender:	M	F
ID no:				Age:		
Surname: Mother / Step-mother				Full name(s)		
Date of Birth:	DD	MM	CCYY	Gender:	M	F
ID no:				Age:		
Also known as:				Names and ages of siblings or other children if helpful for tracking		
Street Address (include postal code):					Postal Code:	

(*) = Complete if available or applicable

SURNAME OF CHILD:	
FULL NAMES OF CHILD:	

6. ABUSE											
Date of Incident:			Date unknown:			Episodic/ongoing from (date)			Reported to CPR:		
DD	MM	CCYY				DD	MM	CCYY	DD	MM	CCYY
Place of incident:											
<input type="checkbox"/> Child's home <input type="checkbox"/> Field <input type="checkbox"/> Tavern <input type="checkbox"/> School <input type="checkbox"/> Friend's place <input type="checkbox"/> Partial Care <input type="checkbox"/> ECD Centre <input type="checkbox"/> Neighbour <input type="checkbox"/> Child and youth care centre <input type="checkbox"/> Other (specify) <input type="checkbox"/> Foster home <input type="checkbox"/> Temporary safe care											
6.1) TYPE OF ABUSE (Tick only the one that indicates the key motive of intent)											
Physical			Emotional			Sexual			Deliberate neglect		
6.2) INDICATORS (Check any that apply)											
<u>PHYSICAL:</u> <input type="checkbox"/> Abrasions <input type="checkbox"/> Bruises <input type="checkbox"/> Burns/Scalding <input type="checkbox"/> Fractures											
<input type="checkbox"/> Other physical illness <input type="checkbox"/> Cuts <input type="checkbox"/> Welts <input type="checkbox"/> Repeated injuries											
<input type="checkbox"/> Fatal injury (date of death) <input type="checkbox"/> Injury to internal organs <input type="checkbox"/> Head injuries											
<input type="checkbox"/> No visible injuries (elaborate)				<input type="checkbox"/> Poisoning (specify)				<input type="checkbox"/> Other Behavioural or physical (specify)			
<u>EMOTIONAL:</u> <input type="checkbox"/> Withdrawal <input type="checkbox"/> Depression <input type="checkbox"/> Self destructive aggressive behaviour											
<input type="checkbox"/> Corruption through exposure to illegal activities <input type="checkbox"/> Deprivation of affection											
<input type="checkbox"/> Exposure to anti-social activities <input type="checkbox"/> Exposure to family violence											
<input type="checkbox"/> Parent or care giver negative mental condition <input type="checkbox"/> Inappropriate and continued criticism											
<input type="checkbox"/> Humiliation <input type="checkbox"/> Isolation <input type="checkbox"/> Threats <input type="checkbox"/> Development Delays <input type="checkbox"/> Oppression											
<input type="checkbox"/> Rejection <input type="checkbox"/> Accusations <input type="checkbox"/> Anxiety <input type="checkbox"/> Lack of cognitive stimulation											
<input type="checkbox"/> Mental, emotional or developmental condition requiring treatment (specify)											
<u>SEXUAL:</u> <input type="checkbox"/> Contact abuse <input type="checkbox"/> Rape <input type="checkbox"/> Sodomy											
<input type="checkbox"/> Masturbation <input type="checkbox"/> Oral sex area <input type="checkbox"/> Molestation											
<input type="checkbox"/> Non contact abuse (flashing, peeping) <input type="checkbox"/> Irritation, pain, injury to genital											
<input type="checkbox"/> Other indicators of sexual molestation or exploitation (specify)											
<u>DELIBERATE NEGLECT:</u> <input type="checkbox"/> Malnutrition <input type="checkbox"/> Medical <input type="checkbox"/> Physical <input type="checkbox"/> Educational											
<input type="checkbox"/> Refusal to assume parental responsibility <input type="checkbox"/> Neglectful supervision <input type="checkbox"/> Abandonment											
6.3) Indicate overall degree of Risk to child:											
<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Unknown											
6.4) When applicable, tick the secondary type of abuse Multiple Abuse: <input type="checkbox"/> Yes <input type="checkbox"/> No											
Sexual			Physical			Emotional			Deliberate Neglect		
Brief explanation of occurrence(s) (including a statement describing frequency and duration)											

(*) = Complete if information is available or applicable

SURNAME OF CHILD:	
FULL NAMES OF CHILD:	

7. MEDICAL INTERVENTION (*)		
Treated outside hospital: <input type="checkbox"/> Yes <input type="checkbox"/> No	Examined by: <input type="checkbox"/> Doctor <input type="checkbox"/> Reg. Nurse	Hospitalised: <input type="checkbox"/> For assessment <input type="checkbox"/> For treatment <input type="checkbox"/> As place of safety
Where (name of Hospital)	Contact person	Telephone Number

8. CHILDREN'S COURT INTERVENTION (*)			
Removal of child to temporary safe care (Section 152): <input type="checkbox"/> Yes <input type="checkbox"/> No		Date	
		MM	DD CCYY

9. SAPS: (ACTION RELATED TO ALLEGED ABUSER(S)) - (*)				
Reported to SAPS: <input type="checkbox"/> Yes <input type="checkbox"/> No	Charges laid: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date		
		DD	MM	CCYY
CASE NR	Police Station	Telephone Nr		
Name of Police Officer		Rank of Police Officer		

10. CHILD KNOWN TO WELFARE ORGANISATION/ SOCIAL DEVELOPMENT?		
10.1) Child known to welfare?: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name of Organisation	Contact number	Reference number

11. DETAILS OF PERSON WHO REPORTS ALLEGED ABUSE (Refers to a profession, mandatory obliged to report child abuse)		
Name of informant	Employer	
Employer Address	Work Telephone Nr	Fax Number
Email Address		

(*) = Complete if information is available or applicable

SURNAME OF CHILD:	
FULL NAMES OF CHILD:	

CAPACITY	Caregiver	Correctional Official	Child and Youth Care Centre	Dentist	Doctor	Drop in Centre
Section 110 (1)	Homeopath	Labour Inspector	Legal Practitioner	Midwife	Member of staff – partial care facility	Medical Practitioner
	Minister of Religion	Nurse	Occupational Therapist	Psychologist	Police Official	Physio-therapist
	Religious leader		Social service professional		Social worker	
	Speech therapist		Shelter		Traditional leader	
	Teacher		Traditional health practitioner		Volunteer Worker – partial care facility	
	Other (specify)					

I declare that the particulars set out in the above mentioned statement are true and correct to the best of my knowledge.

Signature of person reporting alleged abuse: _____

Date: _____

Official Stamp of Department / child protection organisation

NAME OF REPORTING EDUCATOR: _____

NAME OF PRINCIPAL: _____

DATE : _____

NAME OF SCHOOL: _____

ADDRESS: _____

CONTACT TELEPHONE: _____
