IHSS Protective Supervision Hazard/Injury Log

Name of IHSS recipient/applicant _____

Case Number _____

Risk of Injury or Harm Activities	Would this happen if you were not watching this person 7 days a week, 24-hour a day? Would they do:	Dates of Occurrence if this has happened?	Comments
Wandering out of the house and getting lost	Yes ☐ No ☐		
Letting strangers in the house	Yes ☐ No ☐		
Turning the stove on and forgetting to turn it off	Yes ☐ No ☐		
Starting fires in the microwave	Yes No		
Lighting small fires around the home	Yes ☐ No ☐		
Leaving water running	Yes No		
Eating dangerous products or unhealthy foods, like soap or laundry detergent	Yes ☐ No ☐		
Eating inappropriate food for medical condition. For example: drinking unlimited soda when a person has diabetes	Yes ☐ No ☐		
Head banging, self-biting and scratching	Yes ☐ No ☐		
Using knives or other unsafe household objects	Yes ☐ No ☐		
Climbing onto a high place and jumping off because he or she is trying to fly	Yes ☐ No ☐		
Hiding in the refrigerator	Yes ☐ No ☐		
Sticking items in light socket or electrical outlet	Yes ☐ No ☐		
Sticking hands in dirty toilet	Yes ☐ No ☐		

Wandering into the street without regard for oncoming traffic	Yes ☐ No ☐		
Jumping into a swimming pool without knowing how to swim	Yes ☐ No ☐		
Trying to move furniture when the individual lacks needed balance and strength	Yes ☐ No ☐		
Using a SOS pads or non-cloth scrubbers to bathe and clean himself or herself	Yes ☐ No ☐		
Trying to walk when it is unsafe to walk unassisted	Yes ☐ No ☐		
Hiding dirty diapers	Yes ☐ No ☐		
Playing with feces	Yes ☐ No ☐		
Hitting mirrors or television	Yes ☐ No ☐		
Standing/sitting on glass table	Yes ☐ No ☐		

DECLARATION

I am a resident of _____ County, State of California and I declare under the penalty of perjury that the information provided above is true and correct.

SIGNATURE OF DECLARANT:	NAME OF DECLARANT	DATE:
ADDRESS:	CITY/ZIP	TELEPHONE: ( )

DOCTOR CERTIFICATION

I certify that I am licensed to practice in the State of California and that the information provided above is correct.

SIGNATURE OF PHYSICIAN OR MEDICAL PROFESSIONAL:	MEDICAL SPECIALTY:	DATE:
ADDRESS:	LICENSE NO.:	TELEPHONE: ( )