

First Aid Report Form

Date:

Location:

Time:

Injured / Ill Person's Details

Family Name: _____ Given Name: _____ Sex: _____ DOB: _____

Address: _____ Telephone: _____

Allergies: _____ Medication: _____

Past Medical History: Not Known Asthma Cardiac Diabetic
 Nil Epilepsy Hypertension Loss of consciousness

Other: _____ Medi Alert- What: _____

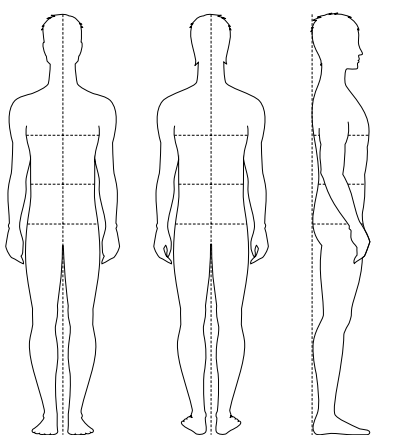
Incident Details

What Happened:

Time (Specify AM/PM)	Breathing (Rate per minute, depth, noise)	Conscious Level (Reponds to: voice, pain, touch)	Other Observation (Eg. Skin colour, temperature, moisture)

Place an X on the affected body area and CIRCLE the type of Injury below:

- A abrasion
- Bl bleeding
- Bu burns
- C contusion
- D deformity
- F fracture
- L laceration
- P pain
- S swelling
- T tenderness



First aid treatment provided:

Consent for treatment given: YES NO

Follow up / Referral: Ambulance Hospital Return to work

Other: _____

First Aider's Name and Signature: _____

Time Completed: _____

Injured / Ill Person's Signature: _____

Parent/Guardian name and Signature:
 If student is under 18 years of age parent/guardian must sign above.

Date: _____ / _____ / _____

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