

FIRST AID TREATMENT FORM

1. Original

2. Copy to:

Details of the person receiving treatment:

Surname: _____ Given Names: _____ Date of Birth: _____ Sex: M F

Field Trip _____

Emergency Contact: _____ Phone #: _____ Emergency Contact Notified: Yes No

Details of the Illness/Injury:

Date _____ Time _____ am/pm Ambulance Requested _____

Where did the event happen? _____ Witness _____

Symptoms: _____

History of Illness/Injury:

Medical History: _____

Hx of Seizures: Yes No Hx of Diabetes: Yes No Medic Alert Bracelet : Yes No When Person Ate /Drank Last: _____

Allergies

Medications

Observations	Time	Time	Time	Assessment
	Level of Consciousness			
<i>Fully Conscious</i>				
<i>Drowsy</i>				
<i>Unconscious</i>				
Pulse				
<i>Rate</i>				
<i>Description</i>				
Breathing				
<i>Rate</i>				
<i>Description</i>				
Skin				
<i>Colour</i>				
Other Observations				

Assessment

Treatment:

Response Team Members in Attendance: _____

Follow up - None Doctor Ambulance Hospital Other _____

Outcome: Admitted to hospital? Yes No

Comments:

First Aider (Print): _____

Time: _____

Copy to PSA Headquarters
 8241 S Walker Avenue, Suite 104
 Oklahoma City, OK 73139
 855-772-4636

Signature: _____

Date: _____