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:_____

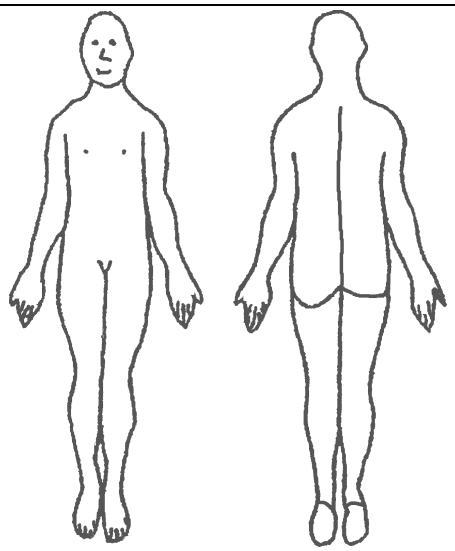
Hx of Seizures: Yes No **Hx of Diabetes:** Yes No **Medic Alert Bracelet :** Yes No **When Person Ate /Drank Last:**_____

Allergies	Medications

Observations	Time	Time	Time
Level of Consciousness			
Fully Conscious *Drowsy* *Unconscious*			
Pulse			
Rate *Description*			
Breathing			
Rate *Description*			
Skin			
Colour			
Other Observations			

Assessment

Abrasion
Burn
Contusion
Deformity
Fracture
Haemorrhage
Laceration
Pain
Rigidity
Swelling
Tenderness



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:	

11/12/14