First Aid Treatment Record Form

Incident Reference Number: _____

Date of Incident: / / Time: am/pm Date of Report: / /

Location:

FIRST AIDER DETAILS

Surname: Given Name:

Phone: Email:

PATIENT DETAILS

Surname: Given Name:

Phone: Email:

Staff ☐ Student ☐ Contractor ☐ Visitor ☐ Company/Organisation:

INJURY/ILLNESS DESCRIPTION

Bruise ☐ Strain ☐ Sprain ☐ Fracture ☐ Abrasion ☐ Laceration ☐ Body fluid exposure ☐

Loss of bodily function ☐ Burn: Chemical ☐ Thermal ☐ Hot / Cold Other:

Conscious ☐ Breathing ☐ Pulse rate: Abnormal skin appearance ☐

Details:

MEDICAL INFORMATION OBTAINED

Medical Alert Bracelet/Necklace ☐ Description:

Patient ☐ Other ☐ Source Details:

Details:

TREATMENT GIVEN

Treatment refused ☐

OCCUPATIONAL EXPOSURE PROCEDURE ACTIVATED

Yes ☐ No ☐

Details:

MEDICAL PROFESSIONAL ASSUMING RESPONSIBILITY FOR PATIENT (if relevant)

SIGNATURES

First Aider: Date: / /

Witness to treatment: Date: / /

Name:

OH&S Officer: Date Received: / /