First Aid Report Form

STRICTLY CONFIDENTIAL

Details of Injured Person:		
Name:		
Address:		
Date of Birth:	Job Title:	
Phone: (home)	(bus)	(mob)
Time of Incident:	Date of Incident:	Day of Incident:
Exact Location of Incident or Hazard:		

INITIAL ASSESSMENT

Please Circle:

Breathing	**Skin**	**Pulse**	**Conscious**
Normal	Normal	Normal	Alert
Shallow	Pale	Slow	Confused
Absent	Flushed	Rapid	Drowsy
Wheeze	Moist/Clammy	Strong	Unconscious
Gasping	Dry	Weak	
Rapid	Sweaty	Not Detected	
Slow	Cool/Cold	Regular	
	Warm/Hot	Irregular	

Notes: *(including abrasions, bleeding, burns, contusions, lacerations, pain, swelling…)*

Treatment:

Referred:

Ambulance Called Y / N If Yes, which Hospital _____

Ambulance Called Y / N If Yes, Doctor's Name Ph:

Staff Name: _____

Signature: _____ Date: _____

Position: _____