

# First Aid Report

Date:  /  /  Time:  :   *am*  *pm*

Victim's name:   *male*  *female* Age:

Victim's phone number:  (  ) -

Your name:

Your phone number:  (  ) -  Signature:

## Consent for first aid:

<input type="checkbox"/>	Yes
<input type="checkbox"/>	No
<input type="checkbox"/>	Guardian consented
<input type="checkbox"/>	Unconscious
<input type="checkbox"/>	Minor without guardian

Contacted EMS:  *yes*  *no* Time:  :   *am*  *pm*

Contacted other service:  *yes*  *no* Time:  :   *am*  *pm*

What service?  (  ) -

## Description of accident/injury:

## Description of first aid given:

Follow-up?  *yes*  *no*

## If yes, detail: