



FIRST AID TREATMENT RECORD

This form is to be kept in a folder near the First Aid box and completed every time First Aid Treatment is given

Date of Injury: / /	Time of Injury:	Location of Injury:
Injured Persons Details:		
Name:	D.O.B:	Gender: (circle) Male/Female
Brief Description of what the persons was doing prior to the injury:		
<p style="text-align: center;">PLEASE INDICATE LOCATION OF INJURY</p> <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;"> LEFT </div> <div style="text-align: center;"> </div> <div style="text-align: center;"> </div> <div style="text-align: center;"> RIGHT </div> </div>		
First Aid Observations:		
Treatment given:		
First Aider Recommendations:		
Is further treatment required: (circle if applicable) YES / NO Hospital/Clinic Where:		
Person administering First Aid: Name:		Date: / /
Incident Reported to: Name:		
Has an incident report been completed: YES/NO If NO ; complete and submit to Supervisor		