

<b>CONFIDENTIAL</b>	<b>NUMBER</b>
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**GHC First Aid Report Form**

Date	Location	Time	
Surname	Christian Name	Sex	DOB
Patient's Address		Tel No	
Allergies?	Medications?		

What happened? How ,where and when

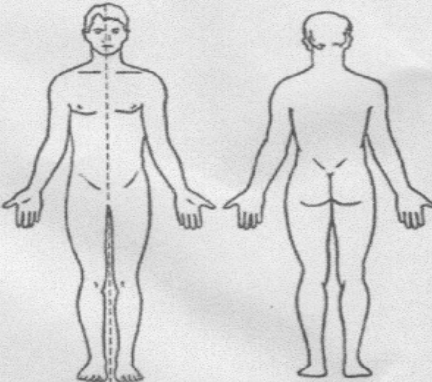
**EH Hospital reporting - tick boxes for everyone sent to hospital to identify match or training, senior or junior, open play or pen corner and what caused the injury - Ball ,stick or body?**

Match	Training	Senior	Junior	
Open play	Penalty Corner	Ball	Stick	Body

**Past medical history**

<input type="checkbox"/> Not known	<input type="checkbox"/> Asthma	<input type="checkbox"/> Loss of consciousness
<input type="checkbox"/> Diabetic	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Hypertension
<input type="checkbox"/> other?	<input type="checkbox"/> Cardiac	<input type="checkbox"/> Medi Alert—what?

Time	Breathing	Pulse	Conscious level Alert Voice Pain Unconscious	Other observations

<ul style="list-style-type: none"> <li>A abrasion</li> <li>Bl bleeding</li> <li>Bu burns</li> <li>C contusion</li> <li>D deformity</li> <li>F fracture</li> <li>L laceration</li> <li>P pain</li> <li>S swelling</li> <li>T tenderness</li> </ul>		<p><b>Treatment</b></p> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
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Discharged how?      Ambulance    Hospital      Own Doctor    Other ?

Witness Name and Signature: must complete if patient refused treatment

First Aider name and signature	Patient signature	Time out
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Once complete - email form to [Michellefussell@gmail.com](mailto:Michellefussell@gmail.com)

ITEMS USED DURING TREATMENT - THESE WILL BE REPLENISHED BY FRIDAY OF WEEK FOLLOWING RECEIPT OF FORM BY FIRST AID OFFICER EG. ICEPACKS X2, EYE WASH X2, MED CREPE BANDAGE X1

1	4
2	5
3	6

CHECKED ON BEHALF OF GHC BY:

Further Action?