First Aid Treatment Form

Please complete form during and / or immediately after the provision of First Aid treatment
Submit completed form to CVI at: **admin@calisthenics.asn.au**

Calisthenics Victoria Inc.

PLEASE PRINT CLEARLY

Event Name/Description:	**Location/Venue Name:**	
Name of First Aider:	**First Aid Treatment Date:**	**First Aid Treatment Time:** AM / PM

Full Name of Injured Person:

☐ Female
☐ Male

Contact details:

Phone (Home): _____

(Mobile):_____

Address:

_____

Parent/Guardian Name (if under 18):_____

Injured Person type:

☐ Participant
☐ Parent
☐ Coach
☐ Volunteer
☐ Adjudicator
☐ Member of Public
☐ CVI Employee
☐ Other: _____

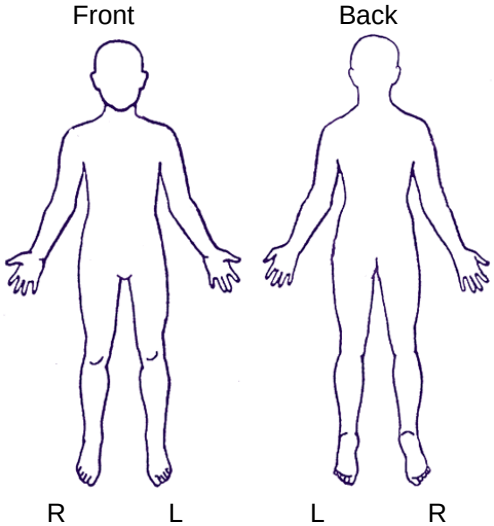
History of Accident or Illness (what happened):

First Aid Assessment (what is the injury/illness):

Time of Observation:	AM/PM	AM/PM	AM/PM
Conscious State 1. Fully Conscious 2. Drowsy 3. Unconscious			
Pulse 1. Slow 4. Rapid 2. Strong 5. Weak 3. Regular 6. Irregular			
Pulse Rate			
Respiration 1. Deep 4. Gasping 2. Shallow 5. Rapid 3. Absent 6. Slow			
Respiration Rate			
Skin 1. Hot 3. Cool 2. Warm 4. Cold			
Pupils Y/N — ***Reactive***	R L	R L	R L
Equal			

Assess Injuries / Symptoms and Signs

1. Abrasion
2. Bleeding
3. Burn
4. Contusion
5. Discolouration
6. Fracture
7. Laceration
8. Pain
9. Sprain
10. Swelling
11. Tenderness



Allergies/Medications/Past Medical History:
Treatment:

Ambulance Called? ☐	**Time of Call:**	**Who Called:**	**Time Arrived:**
Taken to:	☐ **Own Doctor**	☐ **Other:** _____	**Time of Departure:**
☐ **Parent / Guardian Pick-up**	**Time Picked Up:**		**By Whom:**
First Aider Signature:	**Date:**	**Time:**	**Contact Number:**
CVI Office Use Only:	Enter into CVI Register: ☐	Incident Report Submitted: ☐ Yes ☐ No	Incident ID No.: