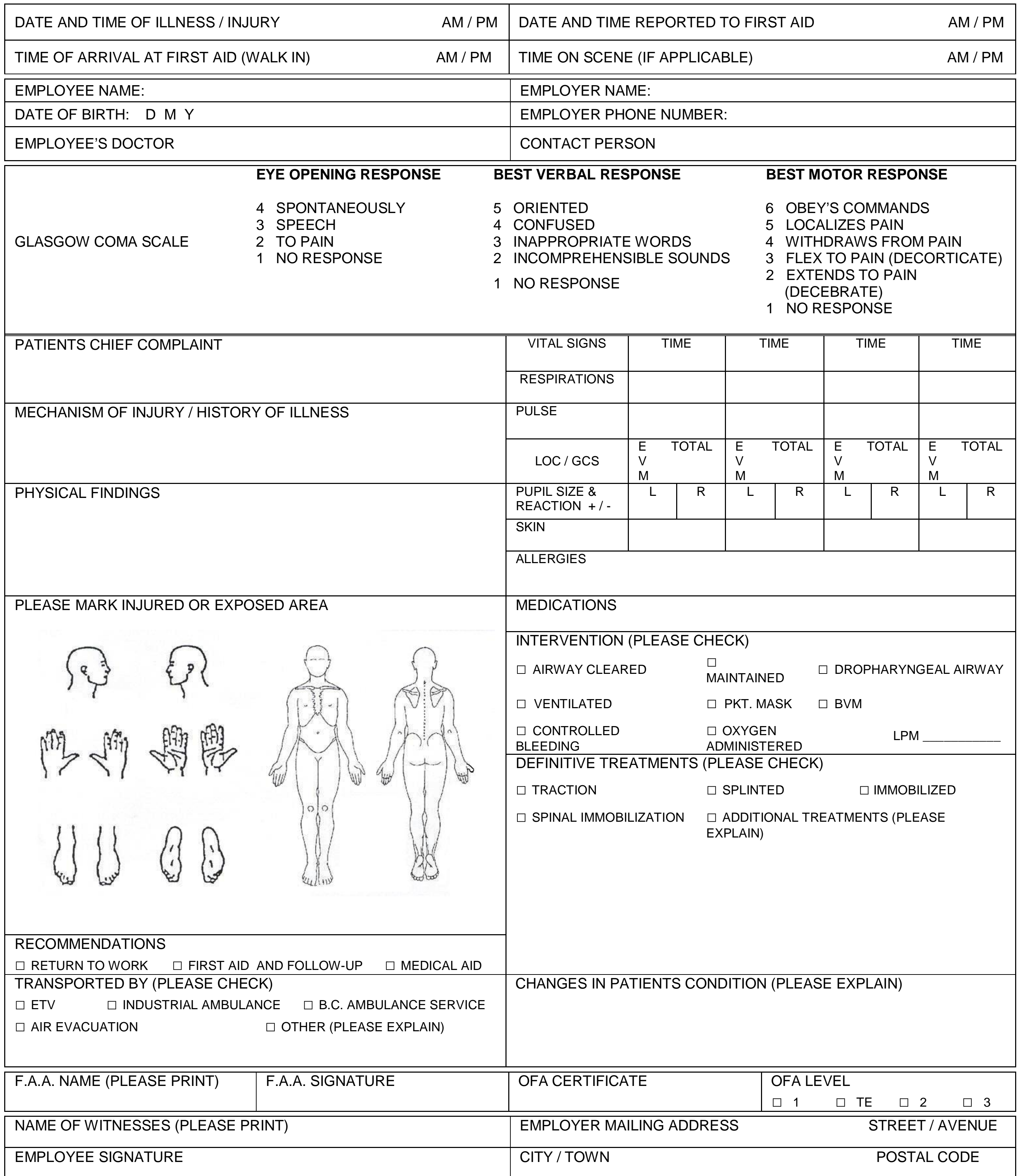
FIRST AID ASSESSMENT RECORD



DATE AND TIME OF ILLNESS / INJURY AM / PM	DATE AND TIME REPORTED TO FIRST AID AM / PM
TIME OF ARRIVAL AT FIRST AID (WALK IN) AM / PM	TIME ON SCENE (IF APPLICABLE) AM / PM

EMPLOYEE NAME:	EMPLOYER NAME:
DATE OF BIRTH: D M Y	EMPLOYER PHONE NUMBER:
EMPLOYEE'S DOCTOR	CONTACT PERSON

	EYE OPENING RESPONSE	**BEST VERBAL RESPONSE**	**BEST MOTOR RESPONSE**
GLASGOW COMA SCALE	4 SPONTANEOUSLY 3 SPEECH 2 TO PAIN 1 NO RESPONSE	5 ORIENTED 4 CONFUSED 3 INAPPROPRIATE WORDS 2 INCOMPREHENSIBLE SOUNDS 1 NO RESPONSE	6 OBEY'S COMMANDS 5 LOCALIZES PAIN 4 WITHDRAWS FROM PAIN 3 FLEX TO PAIN (DECORTICATE) 2 EXTENDS TO PAIN (DECEBRATE) 1 NO RESPONSE

PATIENTS CHIEF COMPLAINT

MECHANISM OF INJURY / HISTORY OF ILLNESS

PHYSICAL FINDINGS

VITAL SIGNS	TIME		TIME		TIME		TIME	
RESPIRATIONS								
PULSE								
LOC / GCS	E V M	TOTAL	E V M	TOTAL	E V M	TOTAL	E V M	TOTAL
PUPIL SIZE & REACTION + / -	L	R	L	R	L	R	L	R
SKIN								

ALLERGIES

PLEASE MARK INJURED OR EXPOSED AREA

MEDICATIONS

INTERVENTION (PLEASE CHECK)

☐ AIRWAY CLEARED ☐ MAINTAINED ☐ DROPHARYNGEAL AIRWAY

☐ VENTILATED ☐ PKT. MASK ☐ BVM

☐ CONTROLLED BLEEDING ☐ OXYGEN ADMINISTERED LPM ___________

DEFINITIVE TREATMENTS (PLEASE CHECK)

☐ TRACTION ☐ SPLINTED ☐ IMMOBILIZED

☐ SPINAL IMMOBILIZATION ☐ ADDITIONAL TREATMENTS (PLEASE EXPLAIN)

RECOMMENDATIONS

☐ RETURN TO WORK ☐ FIRST AID AND FOLLOW-UP ☐ MEDICAL AID

TRANSPORTED BY (PLEASE CHECK)

☐ ETV ☐ INDUSTRIAL AMBULANCE ☐ B.C. AMBULANCE SERVICE

☐ AIR EVACUATION ☐ OTHER (PLEASE EXPLAIN)

CHANGES IN PATIENTS CONDITION (PLEASE EXPLAIN)

F.A.A. NAME (PLEASE PRINT)	F.A.A. SIGNATURE	OFA CERTIFICATE	OFA LEVEL ☐ 1 ☐ TE ☐ 2 ☐ 3

NAME OF WITNESSES (PLEASE PRINT)	EMPLOYER MAILING ADDRESS STREET / AVENUE
EMPLOYEE SIGNATURE	CITY / TOWN POSTAL CODE