

First Aid Treatment Record

1. Original – FAO to file
2. Copy to Nurse/Doctor/Ambulance on request
3. Copy to ill/injured person on request

Details of the illness/injury

Date: ___/___/___ Time: ___ am/pm Campus: Nathan ☐ Gold Coast ☐ Mt. Gravatt ☐ Logan ☐ South Bank ☐

Where did the event happen? Be specific (room and building): _____

Witness details (if appropriate): _____

Description of illness/injury

Details of person receiving treatment

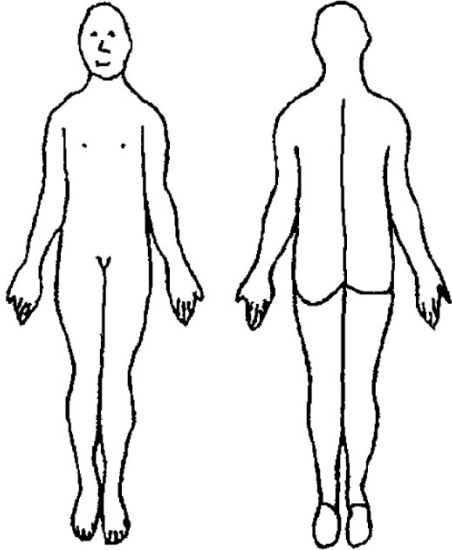
Last Name: _____ Given Names: _____ Date of Birth: ___/___/___ Gender: M ☐ F ☐

Status: Academic Staff ☐ General Staff ☐ Student ☐ Contractor/Employed by Contractor ☐ Visitor ☐

Staff/Student Number: s _____ Element/School/Centre: _____

If staff, Job Title: _____ Continuing ☐ Casual ☐ Supervisor's Name: _____

If Contractor, or employed by Contractor, provide name and address of contractor. If Visitor, provide visitor's address:

Allergies				Medication	
Observations	Time	Time	Time	Bodily location of injury/illness	
Level of consciousness				<div style="display: flex; align-items: center;"> <div style="flex: 1;"> Abrasion Burn Contusion Deformity Fracture Haemorrhage Laceration Pain Rigidity Swelling Tenderness </div> <div style="flex: 2; text-align: center;">  </div> </div>	
Fully conscious					
Drowsy					
Unconscious					
Pulse					
Rate					
Description					
Breathing					
Rate					
Description					
Skin					
Colour					
Other Observations					

Assessment

Treatment

Follow Up/Referral

None ☐ Griffith Health Service (GC/N) ☐ Personal Physician/Doctor ☐ Ambulance ☐ Hospital ☐ Other ☐

Comments

First Aider (Print name):
Signature: _____

Date:
Time: _____

All incidents, near misses and identified hazards must also be reported via [GSafe](#).

[illegible]