Report of Injury or Illness/First Aid Record

Churches of Christ Insurance

COMPLETE ONLY IF INJURY/ILLNESS SUSTAINED

Description of injury/medical condition

Is this an aggravation of a previous injury or condition? Yes ☐ No ☐

Initial Treatment

☐ Nil ☐ First Aid officer ☐ Nurse/Medico ☐ Leader

Name: ……

To be completed by Site/Event First aid officer/Responsible Officer

Observations: ☐ Unconscious ☐ Altered Conscious ☐ Conscious

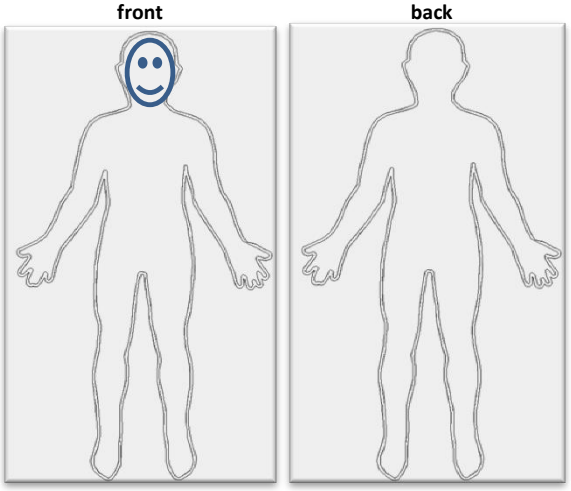
Breathing: ☐ Slow ☐ Normal ☐ Fast

Skin Colour: ☐ Pale ☐ Normal ☐ Flushed

Other observations:

Assessment:

front back



Status of a person at time of completing report

(Church staff Only)

☐ Resumed full work
☐ Ceased work
☐ Partial return work
☐ Returned to alternate duties

Has the injury resulted in loss of work hours?

☐ Yes ☐ No

Time lost: hour/s -

Time lost: days -

Follow up (if known)

☐ Medical Treatment by Health Professional

Name/Dr……

Date:

☐ Ambulance/Hospital

☐ Inpatient ☐ Outpatient

Name of hospital

……

TYPE OF INJURY

☐ Amputation	☐ Head injury
☐ Bruise	☐ Heat stress/exhaustion
☐ Cut/Laceration	☐ Internal injury
☐ Dislocation	☐ Poisoning/toxic effects of substance
☐ Foreign body	☐ Sprains/strains
☐ Fracture	☐ Other (please specify)
☐ Grazes/scratches/abrasions	……

TYPE OF DISEASE

☐ Allergic reaction	☐ Infectious/parasitic
☐ Dermatitis	☐ Loss of consciousness- fainting/seizure
☐ Disease of circulatory system	☐ Psychological
☐ Disorders of muscles tendons & soft tissues	☐ Respiratory irritation/disease
☐ Eye disorders	☐ Other disease (please specify)
☐ Hearing loss	……
☐ Hernia	

BODILY LOCATION OF INJURY - Indicate left or right as appropriate as L or R next to body part

☐ Head	☐ Neck	☐ Shoulder	☐ Hip
☐ Face	☐ Back - upper	☐ Upper arm	☐ Leg - upper
☐ Eyes	☐ Back - lower	☐ Elbow	☐ Knee
☐ Ears	☐ Chest	☐ Forearm	☐ Leg - lower
☐ Nose	☐ Abdomen	☐ Wrist	☐ Ankle
☐ Mouth	☐ Groin/pelvic region	☐ Hands, fingers & thumb	☐ Foot / toes
☐ Head - multiple locations	☐ Trunk - multiple locations	☐ Upper limb-multiple locations	☐ Lower limb - multiple locations

Name of injured person (please print)	Signature:	Date:
If not injured person Name (please print)	Signature:	Date:
Name of team Leader/Leader's nominated representative confirming receipt of report (please print)	Signature:	Date: